

Transformation of Physician Executives: New Accountability for Quality, Performance, Integration Fall 2010

In less than a decade, the role of the physician executive has taken on dramatic, new dimensions. Even as recently as five years ago, physician executives primarily held responsibility for managing medical staff affairs. Increasingly, however, physician executives are moving into pivotal senior management positions with accountability for quality of care, patient safety, financial performance and physician alignment and integration across the healthcare enterprise.

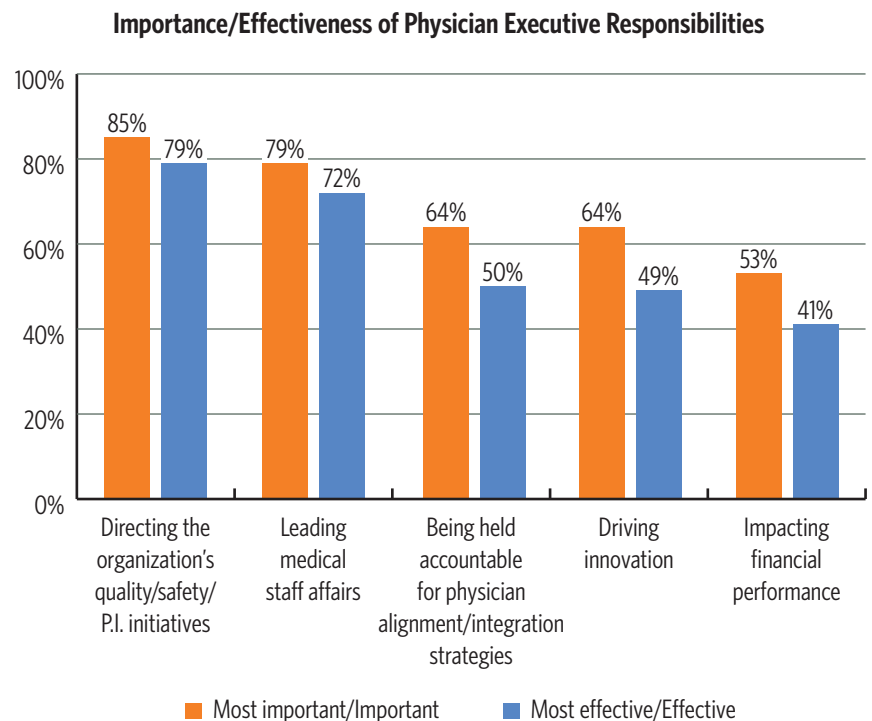
This transformation to a more robust, complex and integral executive management role brings greater expectations, specific expertise and skills requirements and leadership development challenges, according to a national survey of more than 4,000 CEOs conducted by Witt/Kieffer in June 2010. The results indicate substantial shifts in how CEOs view the responsibilities and effectiveness of physician executives, compared to results of a similar survey Witt/Kieffer conducted in 2000.

Traditional medical staff role shifts to broader system responsibility

In Witt/Kieffer's 2000 study, respondents indicated the most important responsibilities of physician leaders were aligning system and physician incentives, developing and monitoring best practices and advising the CEO, COO and governing board. Ten years later, a growing number of hospitals and physician group practices have expanded the role of the most senior physician executives well beyond these traditional duties.

The 2010 study shows that CEO respondents rate the senior physician executive's most important responsibility is directing quality, safety and performance improvement initiatives. The second most important responsibility is still leading medical staff affairs, according to survey results, but much of that now pertains to the third most important responsibility: being accountable for physician alignment/integration strategies. Driving innovation and having an impact on financial performance round out the most important roles for the senior M.D. leader.

"Physician leaders are deeply embedded and involved with all aspects of the operations," says the CEO of an academic medical center. "Of the top four leaders (at my facility) three



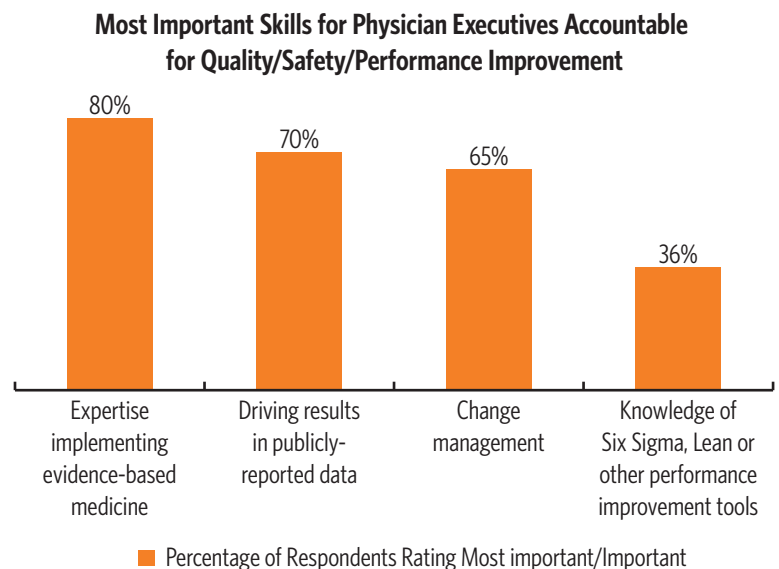
are physicians. Physician leaders want to be involved in the management of the system and not serve as a liaison to the medical staff responsible for 'selling' the hospital administration decisions, i.e., the traditional VPMA job."

"Physician leadership in reducing patient care variations and [promoting] physician alignment/integration are crucial to cost effective, quality care and profitable hospital operations," according to another AMC CEO. However, acknowledging the value of physician leaders does not always go hand-in-hand with their ability to deliver desired results. The survey highlights some disparities between the importance CEOs attribute to senior physician executive responsibilities and how effective they consider the leaders in these roles. For example, more than half the respondents identify impacting financial performance as important or most important, yet only 41 percent rate M.D. leaders effective in that area.

Nevertheless, CEO respondents from all types of organizations — from AMCs to freestanding community hospitals — say eliminating variations in care is by far the area most important for senior physician executives to make an impact on the organization's financial performance. Notably and perhaps not surprisingly, however, CEO respondents from one type of organization — physician group practices — overwhelmingly rank *physician productivity* as the most important area for senior physician executives impacting financial performance. The gap between the perspective of the hospital or system and physician groups reflects the growing conflicting reality of the U.S. healthcare system: physician payment continues to depend on volume while hospital reimbursement rates rise as they treat patients more consistently and efficiently. Health reform will no doubt focus on closing the gap.

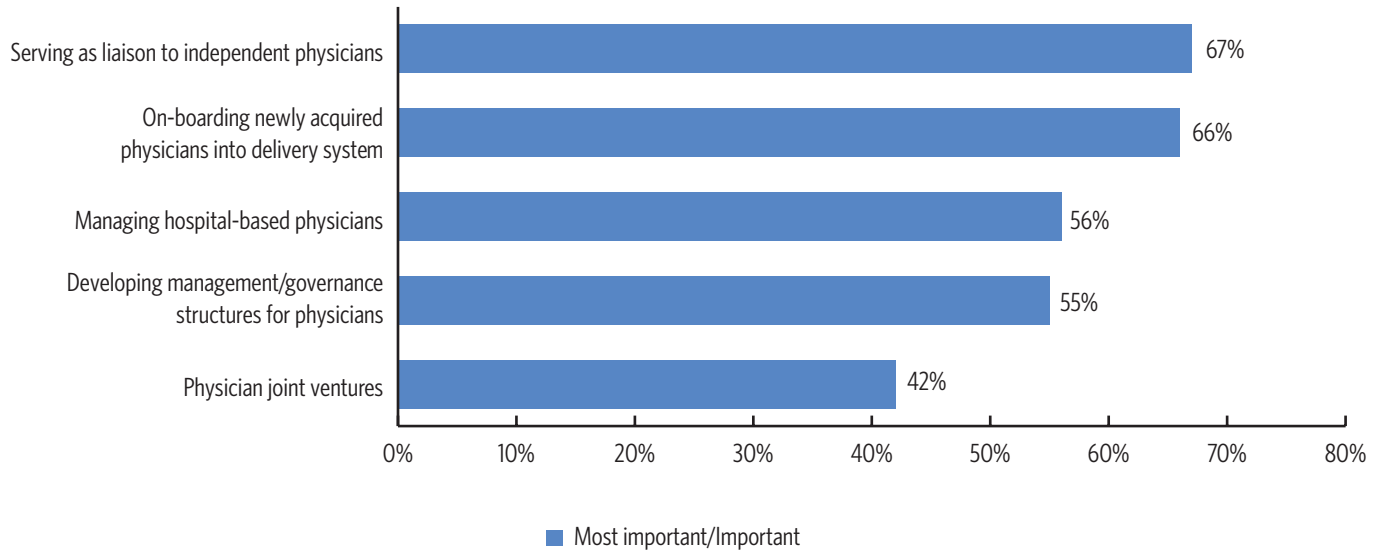
New skills focus on evidence-based medicine, independent physicians

The breadth and depth of skills and expertise now required in senior physician leader roles continue to expand. Similarly, certain areas of responsibility require different and very specific skills and expertise, many far removed from those needed in earlier times. According to a majority of responding CEOs, when senior physician executives are accountable for quality/safety/performance improvement, the most important skill is the ability to implement evidence-based medicine. The second most important skill is driving results in publicly reported data. Understandably, third on the list is change management. Yet, given the importance of the types of skills related to overall performance improvement, it's surprising that barely one-third of the CEO respondents rate tools such as Six Sigma or Lean as important for the senior physician executive to know.



Interfacing between hospital administration and medical staff is the most important skill when senior physician executives are responsible for leading medical staff affairs, according to CEO survey respondents. Next on the list of skills sets important to this role are credentialing, utilization review, physician recruitment/retention and compliance.

Most Important Expertise for Physician Executives Accountable for Alignment/Integration



Advancing patient interests remains most important goal

What CEOs consider the most important goal for any physician executive has not changed over the last decade. Virtually all respondents of the most recent survey cite advancing the interests of patients as most important for any physician leader. That's the same goal CEO respondents said was most important in 2000. In 2010, the overwhelming majority of CEOs respondents also said advancing the organization's interests, benchmarks in quality and safety and hospital/physician alignment are among the M.D. leader's most important goals. Nevertheless, both in 2000 and 2010, the vast majority of CEOs surveyed said advancing the interests of physicians is among the top goals for any M.D executive leader.

Most Important Physician Executive Goals

2000 Survey Results	2010 Survey Results
Advance patient interests (96 percent)	Advance patient interests (98 percent)
Promote strategic thinking (92 percent)	Advance organization interests (97 percent)
Advance physician interests (86 percent)	Advance quality/safety benchmarks (95 percent)
Represent community's health concerns (80 percent)	Advance hospital/physician alignment (90 percent)
N/A	Advance physician interests (85 percent)

Percentage of Respondents Rating Most important/Important

EMR/hospitalists/independent physicians most likely impact on integration

CEOs surveyed were asked to identify factors with the potential for the strongest positive impact on physician alignment/integration, as well as those they perceived as having the potential for the most negative. Electronic medical records, hospitalist programs and the surge in employed physicians have the greatest likelihood of most impact, while physician independence, Stark regulations and less time spent in the hospital pose the biggest threats to physician/hospital integration.

Complex responsibilities require collaborative, full-time leaders

Just over half of CEOs responding to both the 2000 (56 percent) and 2010 (55 percent) surveys report their physician executives practice medicine at least some of the time. Nevertheless, the growing complexity of the senior physician executive position and evolution of responsibilities point increasingly to the need for leaders who devote themselves to full-time roles.

Several survey respondents recognize this changing reality. "Full-time, non-practicing physician leadership is critical," writes the CEO of a free-standing community hospital. Another community hospital leader notes, "We currently have a part-time Medical Director. When we replace him we will hire a full-time CMO with all the above responsibilities [listed in the survey]."

At the same time, healthcare organizations continue to follow several different physician leadership models. One respondent explains that his free-standing community hospital gets strong physician input into its operations through physician members on the board of directors: "Our board's philosophy is to be 'Physician Driven, Physician Led and MBA Managed.'" A leader of a rural community hospital within a system says that four of its 30 employed physicians serve as hospital board members, noting, "We have improved our model and provide for physician leadership in the decision making processes."

Several respondents commented on the value and importance of a collaborative approach. "Physician/non-physician leadership teams will be the most effective form of management and leadership" said one respondent. Another added, "We already have a highly collaborative model after having developed a positive joint venture model over eight years ago." One respondent from a physician group practice states, "The model that seems to be working is the management dyad. The point here is it is unrealistic to assume that the M.D. /M.B.A. person can do it all."

One respondent views a move to a more collaborative perspective as "critical framework for the future performance of medicine. Current physician education needs to begin fully embracing the collaboration challenge of medicine, versus continuing to propagate the notion of physician as captain of the ship."

Impact on Physician Alignment/Integration

Respondents Rating Strongly positive/Positive	Respondents Rating Strongly negative/Negative
Electronic medical records (86 percent)	Physicians' independent/autonomous nature (32 percent)
Hospitalist programs (78 percent)	Stark regulations (27 percent)
Physicians seeking employment versus independent practice (76 percent)	Fewer physicians spending time in the hospital (24 percent)
Increased market competition (74 percent)	Physician manpower (fewer graduates, aging workforce) (18 percent)
Bundled/global payments (73 percent)	Managed care contracts (17 percent)

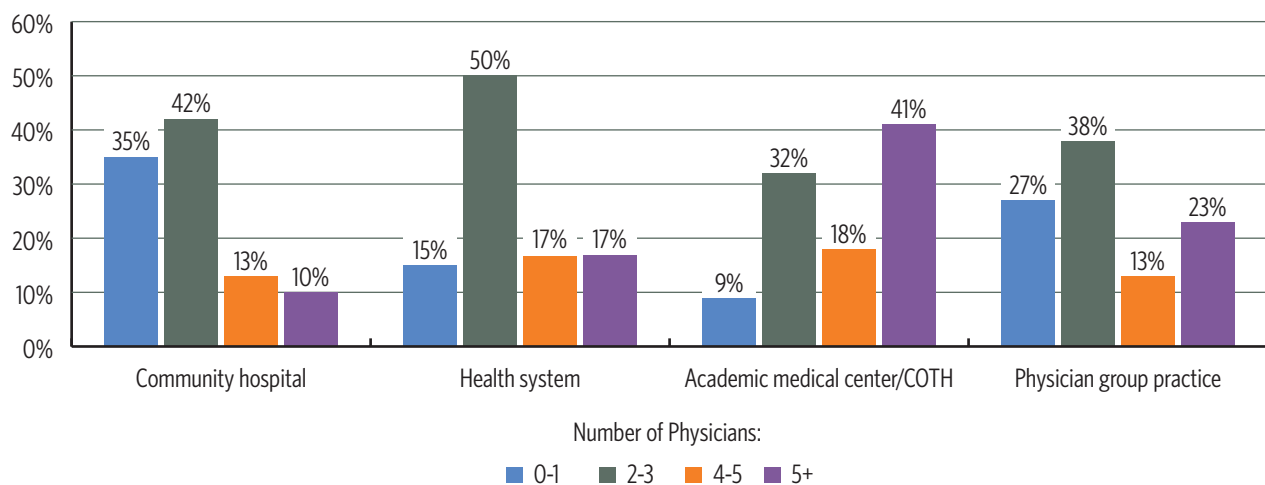
Despite growing demand, pool of potential leaders remains shallow

The shifting healthcare landscape and growing demand for physician leadership heighten the importance of effective physician leadership development, especially given scant numbers of potential leaders reported in the pipeline, limited tenure and little management training.

Thirty-five (35) percent of CEO respondents report their most senior physician executive has less than two years tenure on the senior management team. This suggests few physician executives today have the necessary experience to take on broader leadership roles. Likewise, less than one-third (30 percent) of respondents report their most senior physician leader has a business/medical management degree. While only 21 percent of the positions currently require a degree, it seems likely this number will rise as responsibilities broaden in scope and complexity and additional management training becomes requisite for success.

Where do organizations find M.D. leaders? Mostly from within. Nearly three-quarters (73 percent) of senior physician executives were promoted from within the organization, according to the survey results. Leaders in the pipeline are much more likely to be found at academic medical centers and Council on Teaching Hospitals organizations. Forty-one (41) of those organizations report five or more potential M.D. leaders likely to move up. At the same time, more than half of CEO respondents overall report only 1-3 potential leaders in the pipeline.

Physician Executives in the Pipeline by Organization



The physician executive role is a “critical position for the future with a shallow pool of candidates,” says a CEO respondent from a multi-hospital health system. Similarly, the administrator of a physician group practice comments, “There isn’t much raw talent out there. Physician training is antithetical to administrative and management concepts.”

Pressing need to invest in M.D. leadership development

Despite fundamental changes to how hospitals and physicians interact and provide high-quality, cost-efficient care, organizations are typically offering relatively passive development opportunities for M.D. leaders — exposure to the board and other stakeholders and general encouragement to broaden their knowledge base. According to the survey results, more concrete development opportunities, such as executive coaching, individual action plans and formal succession planning are among the least common offered.

Most Common Leadership Development Opportunities Available	Least Common Leadership Development Opportunities Available
Exposure to Board and stakeholders (77 percent)	Executive coaching (37 percent)
Encouraging potential leaders to broaden knowledge base (65 percent)	Individual action plans (31 percent)
Mentoring (52 percent)	Stretch assignments (26 percent)
Leadership Academy (44 percent)	Formal leadership succession planning (25 percent)
Bundled/global payments (73 percent)	Managed care contracts (17 percent)

Percentage of Respondents Rating Availability

Survey respondents suggest that efforts to expand responsibility and increase physician executive participation in senior management will continue to gain momentum. “We will be recruiting two additional physician executives during the next 12 months — a CMO, who will have overall leadership responsibility for quality/patient safety, and a VP for Clinical Affairs, who will be the senior medical officer for our faculty clinical organization with responsibility for external physician relationships and business growth,” says an AMC respondent.

Other respondents who do not currently have physician executives on board indicate they see value in adding them and are either laying the foundation for incorporating physician leadership, creating a new leadership position or planning to hire a physician executive soon.

Shaping a new reality in physician leadership

In an increasing number of healthcare organizations and physician practices today, physician executives are moving from adjunct management positions into integral roles with comprehensive leadership responsibilities. This fundamental transformation of the physician executive in turn creates a vital need for expanded leadership development strategies and opportunities. Effective leaders cannot develop in a vacuum — they need a supportive and visionary environment, rigorous training in specific skill sets and an in-depth understanding of the critical issues healthcare organizations face, now and in the future.

Survey demographics

Although 80 percent of healthcare organizations surveyed have physician executives on their senior management team, the typical respondent — more than half or 58 percent — report their organization has 1-2 physician leaders. Multi-hospital health systems, AMCs/COTHs and physician group practices are most likely to have 5 or more physician executives in senior management positions. Of the organizations that have no physician executives in senior management, more than half are community hospitals.

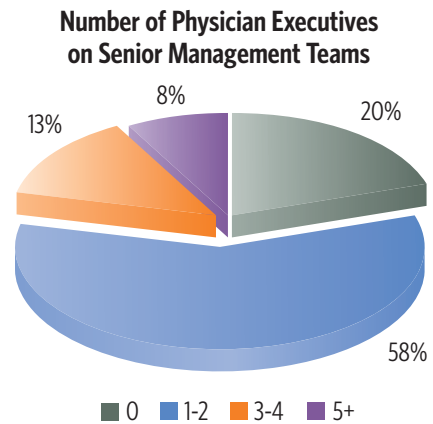
The most commonly held title for all physician executives is Chief Medical Officer (CMO)/VP Medical Affairs (VPMA), according to 85 percent of CEO respondents with the most senior physician executive also likely to be the CMO/VPMA, reported by 67 percent. In the 2000 survey, 40 percent reported VP or SVP of medical affairs as the most common title, followed by 10 percent Medical Director and 8 percent Chief Medical Officer.

Many titles virtually non-existent in 2000, but reported in the 2010 survey, include Chief Quality Officer/Medical Director of Quality, Chief Executive of Employed Physician Groups, Chief Medical Informatics Officer, Chief Executive Officer, Chief Clinical Integration/Alignment Officer and Chief Operations Officer.

In 2000, 85 percent of CEO respondents said the physician executive reported to the CEO or system CEO. In 2010, 78 percent say the most senior M.D. leader reports to the CEO; other new reporting relationships include the COO and board of directors. A few also report dual reporting relationships, for example, the M.D. leader reports to both the CEO and system CMO or the CEO and the board.

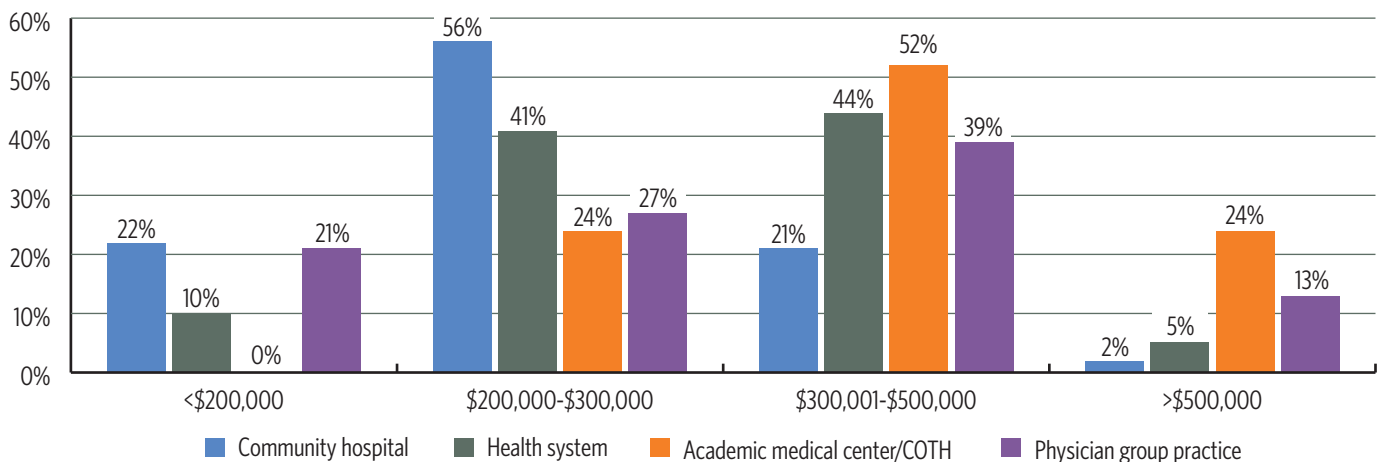
Thirty (30) percent of respondents represent free-standing community hospitals. Other organization types include systems and hospitals within systems (44 percent), physician group practices (16 percent) and academic medical centers/COTHs (6 percent). Four (4) percent represent other organizations, such as hospice facilities and ambulatory surgery centers.

Compensation varies widely by type of organization, with senior physician executives from AMCs/COTHs more likely to earn salaries above \$500,000.



4,324 CEOs surveyed, 8 percent response rate.

Physician Executive Annual Salary by Organization Type



About Witt/Kieffer

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We conduct executive searches on behalf of hospitals, health systems, integrated delivery systems, academic medical centers, medical schools and physician group practices, as well as universities, colleges, associations, community service agencies and other not-for-profit institutions.

The Physician Integration & Executive Leadership practice identifies experienced physician leaders in a wide variety of roles including among others chief medical officer; vice president of medical affairs; president, employed physician groups; chief clinical integration officer; chief medical informatics officer; and increasingly, CEO and COO. The practice comprises search professionals with clinical and/or administrative backgrounds, including physicians who have experience in navigating the structure and relationships between physicians and healthcare delivery systems.

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