



Physician Integration and Leadership Performance

A White Paper for Health
System Boards and Executives

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The Game Has Changed Dramatically

Executive Summary

The emerging healthcare environment has changed the game for healthcare organizations and for physician leadership. The turbulence of that environment is going to require what could be called “agile organizations.” Whether the challenge is growth and the integration of physician practices, creating Patient Centered Medical Homes or Accountable Care Organizations, developing integrated delivery systems or improving cost and quality, agility will be key.

And 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 healthcare organizations, whether they be systems, hospitals or large physician practices.

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

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. Design also includes ensuring that supportive processes, technologies and relationships are in place.
2. **Recruit the best talent to the roles** – recruiting internally and/or externally and either building internal talent or buying external talent
3. **Create flexible compensation designs** - match the roles and recruiting requirements while conserving resources (don’t throw money at it).
4. **Develop leadership capability following the 80%/20% rule** – allocating 80% of attention

and resources to carefully customized just-in-time on-the-job-training and 20% to formal “pipeline” programs/institutes.

5. **Be worthy of the Physicians Who Say “Yes” to Leading** – execute the first four 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 healthcare environment?” is “Yes.”

The Five Challenges for Trustees

1. Understand the nature of the current and evolving healthcare 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 for building such a web
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.

The Four Game Changers—The Challenge

The healthcare environment has certainly not been without change, but it is on the edge of change that could dwarf what we have seen previously. It is likely that the changes will come in waves and that they will be focused much more on physician practices and their integration with hospitals than were previous changes.

That means that most healthcare organizations will see a rapidly expanding gap between the quantity and quality of physician leadership that they have available and what will be required for sustained success, even in the near future. There are many good physician leaders and a significant number are exceptional, but there simply aren't enough to meet the leadership needs of organizations in the emerging healthcare environment. The game has changed and we need to get on a fast track in tapping what is an extraordinary pool of potential physician leaders.

Characteristics of the Coming Changes in Healthcare

The four game changers in the emerging healthcare 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 Will be the Driver. Change will be driven by new and still forming financial requirements. Prior to about 1980 finances were plentiful enough to not require much physician leadership in the corporate realm. Between 1980 and 2010 financial pressure increased significantly on the balance between the business of healthcare on one hand and the care of patients on the other. There was a comparable increase in the need for physician leadership, although efforts in that area were spotty.

Healthcare finances post 2010 will drive a dramatic increase in the need for physician leadership. That leadership will be essential for controlling cost and linking it to quality, building revenue and accepting and managing risk at increasingly challenging levels. The agility to do that will simply not be possible without significant increases in both the quantity and quality of physician leadership.

2. Clinical Transformation Will Be at the Heart. Success will require clinical transformation of varying degrees to achieve the integration, quality and cost management required. The ability to effectively integrate systems of care will be the leverage point for leaders. The challenge is that integration crosses many boundaries and many complex systems and processes as well as involving a diverse group of stakeholders.

That requires aligned competent leadership in each stakeholder group with physicians being the make-or-break group. Integrated and synergistic systems of care can be designed on paper, but they can't be actually brought into being and sustained without physician leadership.

3. Enhanced Information Systems Will Be 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 management information – both clinical and administrative. The IT function is also essential for linking the collaborative efforts of the various stakeholders.

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

Physician leadership is required upfront in the design phase as well as in the implementation and performance phases. While very important in design, it is essential in implementation and performance.

4. The Impact Will Be Complex and Enterprise-Wide. Change will come in varying combinations of strategy, structure, roles, processes, technologies, relationships, required competencies, leadership style and culture. Because of the high degree of interdependence in healthcare, changes in one part of the organization will naturally ripple out into other parts of the organization or system.

Because significant changes will keep coming, organizations will consistently be thrown out of alignment and must be re-aligned 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, a web that can influence widely and effectively.

For Trustees

It is critical that Boards educate themselves about this environment, the implications for the organization and the degree of chronic stress under which the CEO and senior team will be operating. This is a different game and it requires more of Boards than before because of the fluidity of the environment and the changing nature of its requirements. Strategies will often have to evolve and sometimes change significantly to keep up and operational performance will be under increasing demands. Boards need to be as agile as the senior executives.

Agile Organizations – The Solution

These waves of change will require what can be called agile organizations and these change adept organizations will require far more physician leadership than previously seen. Being an agile organization means having the ability to make consistent good choices of strategy and the ability to effectively and efficiently implement those strategies – and then do it again. It means doing so in a way that the organization and its people are enhanced, not diminished.

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 and complementary knowledge and skills
4. High levels of trust and low levels of fear
5. Teamwork with alignment across boundaries
6. Flexibility and resilience
7. Creativity and innovation and the ability to spread the innovation rapidly
8. Common ground on key issues, approaches and style
9. Effective accountability and rapid responses
10. The ability to become stronger with every change – even the toughest

Physician leadership development in this scenario is really about taking healthcare organizations to the next level of performance and creating agile organizations that can sustain that performance in the emerging challenges of the healthcare field. The centerpiece is (a) creating a critical mass of highly competent physician leaders and (b) creating the organizational architecture and culture within which they can effectively lead.

Physician Leadership Webs – The Missing Piece

Leadership webs are designed to provide the leadership power, reach, credibility, flexibility and resilience required by today's healthcare environment. Using the analogy of a web (think spider's web, for example) has a surprisingly powerful impact on executives' thinking about their leadership architecture. A spider's 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.

It 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 the Required Leadership Web

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 formal and informal roles, large and small roles, roles that are ongoing and roles that are time and task specific
4. Large formal ongoing roles are limited
5. The variety of leadership roles closely matches the key work of the organization
6. The competencies of the physicians in each specific role match the work of that role
7. Physician leadership development is customized to the role and physician and it is deliv-

ered 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
9. Compensation is flexible - a combination of salaries for the large formal roles and flexible reimbursement for most roles
10. Compensation closely matches the work load required and is related to outcomes

For Trustees

Trustees that appreciate the emerging healthcare 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 in the Board about the value it is adding and confidence within the executive ranks that the Board will both challenge and support them appropriately. Creating extended webs of high-performing physician leaders is new territory for most organizations, so the confident alignment of Boards and senior executives is essential.

The Five Core Strategies for Building a Physician Leadership Web

Building a web of physician leaders is very straightforward. It involves five core strategies: design the web, recruit the right talent, design flexible compensation models, build the required competencies 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 the priority work and desired outcomes for the organization and design leadership roles to fit.** 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 to be done and design the roles to match that work.

The design can include large and small roles, formal and informal roles, roles that are ongoing and roles that are time and task specific. The reason to maintain as much flexibility as possible is to ensure that roles can be matched to work as priority work changes.

- 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 CMO and VPMA. Some will become new traditions such as Chief Quality Officer or Chief Clinical Information Officer. The most flexible roles will be project or initiative specific, such as leading PCMH implementation, the effective use of EMRs or the development of integrated delivery systems. 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. And then adapt as the healthcare challenges change.
- 3. Keep, start and stop (don't just add roles and throw money at it).** Creating the design of a physician leadership web is not a matter of just adding roles and throwing money at it.

It is a matter of going through a thoughtful and disciplined process of determining three things. What roles do we want to keep (and why)? What roles do we want to add (and to achieve what outcomes)? What roles do we want to stop or redesign? Not only does that process match work with leadership roles, but it also opens up the possibilities in rethinking current roles and identifying new and exciting roles. Not only can talent be deployed or re-deployed, but the same is true of financial resources. Money can be saved and reallocated by altering or ending current roles. Additional financial resources may be necessary, but redeploying funds already in the budget needs to 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 the desire to have departments, organizations or demographic groups represented. There are no longer any “throw-away” roles, no longer room for mediocrity in physician leadership and there is a compelling demand 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 and their roles can expand to take advantage of the capability. It is better to start with smaller roles that can be rapidly expanded to match developing capabilities than to overwhelm new leaders.
- 6. Make room for new leaders and don't burn out the veterans.** Much of the opportunity and the organization's agility will come from developing a variety of roles of smaller scale and scope – or teaming on an initiative - to bring newer leaders into the game and keep

those in larger roles from being overwhelmed. Some of the larger roles may be broken up to allow greater focus, new players and less stress on physicians in current roles of large scale or scope.

7. Avoid the “Sink or Swim” Approach. If you can choose or craft the battlefield, you can probably win the battle. That’s also true in the realm of physician leadership. We need to avoid the classic trap of taking people who have proven themselves masters in a technical domain and throwing them into a leadership domain – with magical thinking that says they will immediately be successful.

The key is to prepare the leadership realm for each physician leader so that they start out supported and able to achieve some quick wins. That includes identifying the key relationships they 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 some basic guidance in how to achieve them. This is an obvious complement to the fourth core strategy (customized development plans).

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 agenda, getting the resources they need to support them, 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 – and that the Board will be paying attention.

Strategy #2: Recruit the Right Talent – Internally (Build) and/or Externally (Buy)

Because each physician leadership role is now such a critical piece of the leadership web, the question of “Where do we find the right talent?” becomes a critical one. Essentially, we can either “build” the talent internally or we can “buy” the talent 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 matters)?
- How big is the external pool for this leadership role?
- How competitive can we be in recruiting in the market?

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

This is not a hard and fast rule, but each of the three types of leadership role has a bias regarding the build/buy question.

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.
2. **New roles**, such as CMIO or Chief Referral Officer, can be filled internally if the talent 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 will also influence the decision. For example, the Chief Referral Officer role may argue for an internal choice because of 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 usually argue for a build approach. 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 take advantage of existing talent.

Strategy #3: Design Flexible Compensation Models

As with the build/buy question, the three types of leadership role will each influence the nature of the compensation design. Leadership flexibility comes in keeping as much compensation as possible tied to the critical work of the organization at any point in time. When that work is done the compensation can be redeployed to the work that becomes the priority. This is particularly true for the flex roles and true for many of the new roles. It argues for tying compensation, where possible, to the specific work and outcomes and that will mean a very creative approach.

Traditional Roles usually have good data nationally and locally that can be used to design a competitive package that meets the standards of "fair market value." Total compensation packages will usually be the classic form of base salary and benefits with possible variable options.

New Roles will vary with some having good data and some (because they are new nationally) having little or no comparative data. For the latter, it will require extremely careful thought about the value/outcomes of the role and the complementary compensation design. If we stay with our earlier examples, the CMIO role will have better comparative data than the Chief Referral Officer role because, while relatively new, it is not nearly as rare.

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

Flex Roles will mostly have little or no relevant data nationally or locally. 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 is the type of role that really requires creativity.

Please Note. In many cases physicians taking on leadership roles will also still be practicing medicine (on salary or not) and compensation will need to be designed to fit that reality.

For Trustees

On the one hand, Boards need to be knowledgeable enough about the first three core strategies to support senior leadership in designing competitive approaches to recruitment and compensation. On the other hand, Boards also need to exercise their duties in the wise use of resources and compliance with fair market value principles. With some key physician leadership roles Trustees can also play a key part in recruitment.

Strategy #4: Customize Physician Leadership Development

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

This is not an either/or issue. Most organizations need both approaches, but most have the wrong balance. The right balance supports the customization of a development plan that matches a physician's specific development needs – and it achieves a significant impact sooner.

Several key actions support this strategy.

1. **Map the competencies to be developed for the physicians in their specific roles.** There will be a few core competencies that need to be developed for all physician leaders – but only a few. Most of physician leadership development needs to be customized to a physician in a particular role. Each leadership role will have capabilities attached that are required to get 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?”
2. **Employ multiple methods of development.** This is critical for both the OJT/JIT development and the more formal pipeline. There are many methods for development, ranging from courses, seminars and conferences to online education, shadowing, carefully crafted job

assignments, partnering and coaching. The leverage is in creating the right combination of methods for the particular physician in the specific leadership role.

3. **Create a sense of joint ownership with the physicians.** The focus on customization makes it much easier to create a sense of ownership with each physician and, over time, in the culture as a whole. A sense of joint ownership influences 24/7 and never wears out, so it is worth the investment of energy to create it early in the process. This includes involving the physician as early as possible in determining needs and possible approaches.

Reinforcing both the importance of self-directed learning as well as frequent and informal accountability checks ensures the desired experience and outcomes.

4. **Assign executive responsibility.** Because this approach is significantly different than the norm in healthcare, it is critical to have senior executives own it. Internal HR, Organization Development or Training Departments cannot be asked to make shifts of this degree without senior executive ownership, guidance and sustained support.

The internal departments will naturally have to function to a much larger degree as brokers of leadership development services and partner with executives and physician leaders in the customization process. If it isn't owned at the top, it won't happen – certainly not in a sustained way.

For Trustees

Leadership development often gets lost in the crush of business. It doesn't usually get completely lost, but it does get scaled back and it easily slips into a backwater where it gets less and less attention. The Board can ensure that this doesn't happen with this core strategy simply by continuing to ask questions about how it is progressing, what the outcomes are, what barriers are being encountered that the Board might help with, etc. The Board can also 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.

Strategy #5: 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 healthcare leaders. That challenge is to be worthy of the physicians who say "yes" to the call to lead and put him or herself on the line.

We must acknowledge that we 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 challenge for physicians.

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 or whether it will be business as usual. A lack of commitment in the beginning or wavering on the path is a pretty clear message that the organization is really not serious about physician leadership.

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 go against the entrenched approach to physician leadership development and performance if they don't clearly lead the way.

For Trustees

Trustees can appreciate and acknowledge to all 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 each of the five core strategies. And they can encourage physicians to say "Yes" to leading — assuring them that the organization will be worthy

Physician Whiplash & Physician Strengths

The preparation and approach that makes for good medicine is, in many ways, 180 degrees from what makes for good leadership. This is not a matter of individuals, but simply the way the world works. It needs to be acknowledged and it is one of the reasons why the 5th strategy is so important. The following differences in the nature of medicine vs. leadership make the point.

1. Prescribe & Comply vs. Lead
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
6. Relating Primarily to the Physical Being vs. Whole Beings
7. Relating to Sick/Injured People vs. Healthy People – Different Needs & Nature

Physicians can get whiplash going from being good clinicians to being good leaders.

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

It Comes Down to Commitment and Execution

So there is a balance between challenge and strengths. It is executive commitment and the successful execution of the five core strategies that determine which way the balance tips - whether the strengths become the foundation of physician leadership or are squandered. That commitment and strategy execution is also what will prove that the belief that there aren't enough physician leaders is untrue.

- Gordon Barnhart
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The O'Brien Group is an executive leadership consulting firm that works with healthcare CEOs, Boards, Physician Executives and their teams to strengthen team dynamics, better manage conflict and improve their readiness for reform.

The results: The health systems they work with now tackle big problems with a renewed sense of alacrity, lead their peers on numerous operational measures and have won Top 10 Best U.S. Health System Awards (Thompson-Reuters).

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Special thanks go to Chris Terranova Asselta, Managing Partner of Sullivan Cotter & Associates for her guidance on the Compensation and Build/Buy sections as well as her overall support of this approach to physician leadership.

Sullivan Cotter works with Boards and Executives of health systems and other tax-exempt organizations developing total compensation approaches for executives, physicians and broad-based employees.

Addendum A

The Three Types of Roles for Physician Leaders Overview & Comparison

In designing the architecture of a web of physician leaders it helps to consider three distinct types of roles. Each type of role has its own nature and each offers different benefits. Taken together they offer the chance to customize the physician leadership structure. That customization is designed to very closely match the priority work of the organization, take advantage of existing physician leadership resources and provide flexibility in the leadership structure that is necessary to keep matching the environmental challenges.

For each of the three types of role there are a few examples and a few notes about how to think about them or address them. There are also notes on the likely approaches to questions of how to get the physician leaders (build internally or buy externally), how to compensate them and how to develop them.

Traditional Physician Leadership Roles

These are the roles that have been common in healthcare 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 not overwhelm any one leader and open up opportunities for others) or deleted. The key is to be disciplined in reviewing them and willing to make indicated changes.

Common Examples

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

How to Address Them

- Disciplined choice about keep, redesign or delete
- Good to have, but not priority?
- May keep, but change scope or scale

Watch Out

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

Recruiting, Compensating and Developing

- Build or Buy? Could be Either
- Compensation? Probably Traditional
- Development? Probably Pipeline

New Physician Leadership Roles

With all the changes in healthcare and the need for far more physician leadership, a whole range of new roles is opening up to match the priority work of the organizations. There is a tremendous amount of leverage in carefully designing new leadership roles.

Common Examples

- CMIO
- EVP, Clinical Integration
- 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 and 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 OJT/JIT Initially

Flex Roles for Physician Leaders

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 the priority work is matched. The possibilities are almost endless, so it’s a matter of being disciplined and creative in designing them.

Common Examples

- Coach – Effective EMR Use (multiple)
- Champion, PCMH (multiple)
- Team Leader, Practice Integration
- Consultant, Leading Change (multiple)
- Coach, Impaired Physicians
- Coach for Senior Administrator

How to Address Them

- Can closely match the priority work
- Can be of any scale and scope
- Can morph at any time to maintain the match of priorities & 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? Untraditional
- Development? OJT/JIT

The key is crafting a leadership web that takes advantage of all three types of roles – and continuing to review that design to ensure that the leadership structure always matches the priority work of the organization.

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Addendum B

**Dramatically Increasing Physician Leadership Performance
System Leader Actions and Physician Actions**

| <p>Healthcare System Leader Actions <i>“Worthy of Physicians Making the Leap”</i></p> | <p>Potential Physician Leader Actions <i>“Courage and Commitment to Make the Leap Into Leadership”</i></p> |
|---|---|
| <ol style="list-style-type: none"> 1. Vision. Create a vision of physician leadership in the organization, the outcomes expected and the partnership with administrative leaders 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 the leadership roles 4. Customize. Identify the range of competencies to be developed and a system for customizing the competencies and development methods for each physician leader – and “prepare the ground” for physicians with the right relationships, information, processes etc. 5. 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 of becoming 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, add value wherever possible 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.</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> |

Addendum C

Major Benefits of Increased Physician Leadership Performance “Moving the Needles”

There are major benefits on both sides of the classic balance in healthcare - the care of patients AND the business of healthcare. With the increasing challenges around both finances and quality and a turbulent environment, physician leadership performance is increasingly important in maintaining a healthy balance. Physician leadership needs to be exerted on both sides of the balance.

Ten Key Examples

There are many ways in which a web of physician leaders can “move the needle” for a healthcare 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 are focused 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 healthcare 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 it is required to meet quality and cost challenges
9. The implementation and effective use of electronic medical records – and beyond
10. The ability to position the healthcare system as “The place where the best and brightest want to practice.”

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