Trend Perspective

Toward a New Brand of Faculty Practice Leadership

With Elizabeth Frye, M.D., F.A.C.P.

Movement in healthcare and academic medicine toward improved quality and new cost structures, organizational consolidation and alignment, and clinical integration have resulted in an evolution of faculty practice plan leadership. In this Q&A, Beth Frye, Witt/Kieffer Chief of Operations & Of Counsel, looks at the expanding responsibilities for group practice leaders and the resulting challenges in recruiting these physician administrators.

Have the challenges of running an AMC faculty practice grown in recent years? What accounts for it?

Frye: Yes, there are two major challenges we are seeing. One is that faculty practice plans are trying to evolve into multi-specialty group practices. These plans originated in order to represent individual departments, so it was in the chair's self-interest to ensure their departments did well. Now each faculty practice plan has to promote the success of the integrated enterprise. The challenge is, how do you group-think while at the same time making sure your department is flourishing? Secondly, these practices need to better align with their hospital/system partners so that there is joint recruitment, programmatic growth, and mutual benefit from improved bottom lines.

What skills do these kinds of plan leaders need?

Frye: Plan leaders must show they have the ability to lead across the continuum, inpatient, outpatient, emergency room, long term care, etc. For example, someone in general surgery should be able to bring neurosurgeons, internists, emergency medicine physicians, and other groups together to achieve outstanding clinical outcomes and financial performance. Another necessary skill is an ability to utilize and analyze big data from multiple sources including finance, medical records, quality and outcomes to forecast trends and more importantly, be able to adapt to these trends proactively.

Leaders must have people skills and be able to build relationships among different constituents to reach consensus. The leader must be able to move from strategy to implementation and have comfort working in a matrixed environment where leadership is consensus-driven and not authoritarian.

Is there also a greater learning curve when a new faculty practice leader is hired?

Frye: Yes. The first challenge is how do you relate to the interpersonal competencies needed to succeed in this unique environment? For a new leader, this means learning about colleagues and how you can best work with them.

There is also a learning curve for leaders of plans which are struggling in the marketplace. Some have at-risk financial contracts which present an immediate concern and require focus on optimizing performance.

A third challenge is the move to population health that has come about in the past decade. In many AMCs, patients are referred so that adds complexity to running a practice that already is adapting to a more patient-focused, value-based environment.

The business components of running a faculty practice have gotten more complex, including issues surrounding P&L responsibilities, research funding, physician compensation and incentives, financial oversight and regulation, and performance and improvement metrics. How are group practice leaders developing these abilities?

Frye: Some academic medical centers and health systems have initiated programs around physician leadership development, but this is just a start. There is a huge need for physician leadership development in what I would call physician practice operations, emphasizing those priorities around finances, funding, performance, quality and strategy. Although it is not yet required in many jobs, and the MBA provides a more sophisticated understanding of finances and ways to build effective teams.

Are physician administrators for faculty medical practices staying involved in their research work and clinical practices? What are pros and cons of doing so?

Frye: For most group practice leaders, I don't think it's practical to focus on three components: clinical, research, and administration. We are seeing physician administrators do less research and clinical practice. Ideally, it's very useful for you to see the fruits of the practice's labor. Nevertheless, the responsibilities of running a faculty practice plan usually outweigh the benefits of staying clinically active. Some physician leaders, however, try to keep clinically active in order to maintain clinical credibility with their physician colleagues.

Finally, what does the marketplace look like for experienced faculty practice leaders? What are the primary recruiting challenges for these leaders that you see?

Frye: Good faculty practice leaders are hard to find and can pretty much go wherever they want. As recruiters, we understand that faculty practice plans are in flux. We know the ideal candidate is a person who enjoys building new things and innovating, someone who is comfortable taking on a new career challenge.

Despite the recruiting challenges, I am optimistic. Times of flux are an opportunity to create something better than what you have. I see faculty practice plan leadership continuing to evolve for the better.

About the Author

Elizabeth (Beth) Frye, M.D., F.A.C.P., Chief of Operations & Of Counsel, brings more than 20 years of physician leadership experience in primary and specialty care in both academic medicine and community hospitals. Beth's search practice focuses on integrating physicians into the leadership roles of hospitals, health systems and integrated group practices.

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