Recruiting and Developing Physician Leaders

Best Practices from Witt/Kieffer
# Table of Contents

Introduction: What’s Next for Physician Leadership?  
*By Linda J. Komnick and Christine Mackey-Ross.* ........................................ 1

I. Keys to Recruiting Physician Leaders  
*By Linda J. Komnick.* .......................................................... 3

II. Predicting Physician Executive Performance  
*By Richard Metheny.* .......................................................... 7

III. What Recruiters Look for in a Physician Executive  
*With Linda J. Komnick and Christine Mackey-Ross.* ....................... 10

IV. The Global Market for U.S. Physician Executives is Heating Up  
*By Christine Mackey-Ross.* ................................................... 13

V. Why Doctors Make Good Healthcare CEOs  
*With Kimberly A. Smith, FACHE.* .......................................... 16

VI. The Shifting World of AMC Deans and Department Chairs  
*With Karen E. Otto.* ............................................................ 19

VII. Toward a New Brand of Faculty Practice Leadership  
*With Elizabeth B. Frye, MD, FACP.* ...................................... 22

VIII. The Emergence of the Chief Health Information Officer  
*By Hillary Ross, JD.* ............................................................ 25

Advice for Physician Leaders

IX. Becoming a Physician Executive: Take the Natural Next Step  
*By Jason P. Petros.* .............................................................. 28
X. Career Building: How Physician Leaders Can Stand Out
   By Daniel Dimenstein .................................................. 31

XI. Physician Leaders Must Think Hard About Soft Skills
   By Linda J. Komnick ...................................................... 34

XII. How to Be Smart and Savvy in a Leadership Interview
    By Sue A. LeGrand ...................................................... 37

XIII. Physician Executives: A Resumé Can Make the Difference
      By Stephen C. Davis .................................................. 40
What's Next for Physician Leadership?

The demand for physician leadership in healthcare has never been greater. Physician executives can add a strong clinical perspective to determining the strategic and operational imperatives of today’s healthcare organizations. Physician leaders bring the viewpoint of population health across the continuum and are integral to assisting their colleagues in the transformations necessary for continued success in the new reimbursement and regulatory environments.

The profile of today’s successful physician leader is an individual who is innovative and interdisciplinary, someone who can play the roles of steward, strategist, catalyst and change agent. We have seen the evolution of the physician executive from VPMA to CMO and now to many roles that combine use of their clinical acumen with finance, operations, strategy, quality and many other facets of healthcare delivery, education and research. Physicians in the C-suite are now the norm, including as CEO. The rise in demand at organizations large and small, urban and rural has resulted in a scarcity of candidates prepared – through advanced graduate degrees and through experience – for these positions, making the challenge of identifying potential candidates greater than ever. Hospitals, health systems, academic medical centers and related organizations must be proactive and focused in securing and creating clinical leaders.

This best practices guide covers the current state of physician leadership across the continuum of care and offers suggestions for how leading healthcare organizations can develop, promote and recruit physician leaders. It also provides expert advice on what physicians themselves can do to hone their leadership skills and advance their own careers.
We hope that “Recruiting and Developing Physician Leaders” provides you with clear and useful advice for strengthening physician leadership in your organization.

Linda J. Komnick  
Senior Partner and Practice  
Co-Leader, Physician  
Integration & Leadership

Christine Mackey-Ross  
Senior Partner and Practice  
Co-Leader, Physician  
Integration & Leadership
The demand for physician leaders who can guide their organizations through health reform far outpaces supply, and it is not likely to change any time soon. Given the scarcity, healthcare organizations are in fierce competition with each other to attract and retain physician executives, especially the select few who combine stellar resumés with strong managerial and relational skills.

For hospitals and health systems that want to win the recruiting war for physician leaders, it’s not enough to offer a top salary (many smaller organizations don’t even have this luxury). They must find other ways to endear themselves to qualified candidates.

**Takeaways:**

- Healthcare organizations must show candidates they fully support physician leaders.
- Proactive organizations will recruit physician executives better than competitors.

**Support for the Position**

Organizations need to demonstrate that they have an environment that is conducive for physician leaders to succeed. This isn’t always the case. Physician executive positions — even chief medical officer, for example — are still somewhat new, and many organizations do not fully understand the best way to integrate them into their leadership structure.

One best practice is to establish clearly defined roles, authority and deliverables for physician executive positions, especially those newly created. If a health system is recruiting a CMO, chief clinical integration officer or chief physician executive, its managers must already have laid the groundwork.
by communicating to all stakeholders why the position is important to the organization, soliciting input from those stakeholders about the position’s roles and responsibilities, and establishing where the new leader fits within the governance structure. Even before a candidate search begins, the organization should establish metrics by which the physician executive’s success will be assessed and determine his or her compensation.

Strong candidates will be looking for these signs of preparedness. They also will want to know how, once on board, they’ll be supported in the critical first few months on the job. Will mentoring or coaching be offered, for instance? This can be tricky for organizations in which there are few, if any, physician leaders already in place. It may be necessary to be creative and help new leaders connect with peers elsewhere. A case in point: One large metropolitan system hired a chief medical officer for each of five different facilities. Once the CMOs were in place, they met regularly to share best practices and mentor each other.

Training can be a nice-to-have or even a must-have for many potential physician leaders, and progressive hospitals and health systems are developing their own in-house leadership programs to help identify and develop physician executives. Curricula vary in length and complexity, but the idea is to let talented physicians know that the organization is serious about career development and cultivating the best leaders for its current and future needs.

A Tale of Two Hospitals

Those healthcare organizations that have put in place an environment for success will win the hearts and minds — and, ultimately, the commitments — of qualified physician leaders. It is helpful to consider the tales of two healthcare organizations — Hospital B, as in “behind,” and Hospital A, as in “ahead” — that conducted CMO searches recently, taking quite different approaches and receiving dramatically different results.
I.

Hospital B had little experience in conducting widespread searches for key executives. Its idea of looking for a physician leader was limited — little more than placing an advertisement in the Sunday newspaper and interviewing the modest pool of candidates who applied. Clearly, a hospital looking for a dynamic new physician leader needs to think more broadly and market the position aggressively, both regionally and nationally.

The hospital had other challenges as it began its search. This was not the first time that Hospital B had hired a CMO. It had had several in the past, but none of them came in with significant management or leadership skills. They were all home-grown and had not been given meaningful opportunities to lead. Once in the position, they had little in the way of training or leadership development. As a result, they had no real understanding of the role, nor the authority, scope or duties usually befitting a physician executive. Thus, there was not a template for success for the position.

Fortunately or unfortunately for Hospital B, reality is now setting in. The changes sweeping the industry are pressuring the board and CEO to rethink their roles and bring in a visionary physician leader. The problem is that many candidates have shown lukewarm interest in the position. A few believe it’s “not a good fit” for them. Translation: The job and organization are not viewed as attractive.

Hospital A never had a physician leader. Responsibilities that typically might have been assigned to a CMO were handled by an elected physician leader, namely the president of the medical staff. Over time, the demands of the position — conducting peer review, overseeing clinical program development, dealing with physician behavior issues, leading Joint Commission accreditation efforts and more — became unmanageable. The need for a full-fledged CMO was clear.

The CEO at Hospital A had never worked with a CMO before, but was a progressive thinker and good communicator. Recognizing her limitations, she began consulting with medical staff and hospital leaders about how a CMO
might help and what they felt his or her main responsibilities would be. She worked closely with physicians — especially the skeptics who questioned whether the position was needed or worried that their roles as “informal leaders” within the organization would be undermined and diminished. By communicating openly and by putting many of the senior physicians on the search committee, the CEO got influential physicians to buy in.

The CEO also spelled out goals and responsibilities for the position, again with input from key medical staff. Looking to see what other similar hospitals had done, they established criteria and expectations by which the new CMO would be measured. They budgeted not just for the position’s salary but also for training and mentorship opportunities.

As Hospital A went out into the market looking for its first CMO, it was ready. It knew what it wanted and let it be known that highly skilled physician executives were central to its plans for growth and development. A pool of viable candidates, internal and external, began to emerge. A few of these leading candidates confided that they were won over by Hospital A’s enthusiasm and vision.

The tales of Hospital A and B are based on real organizations and situations. Some organizations just seem to get it when looking for physician leaders — they know that the market is tight and that good candidates expect much more than a handsome salary.

[This article is excerpted from “Recruiting Physician Leaders,” originally published by Hospitals & Health Networks. Permission to reprint has been granted.]
II. Predicting Physician Executive Performance

By Richard Metheny, Practice Leader, Leadership Solutions

We are just beginning to understand how physician executives, individually and collectively, can best lead healthcare organizations. To this end, in 2014 Witt/Kieffer and Hogan Assessment Systems approached Providence Health & Services and Swedish Health Services to conduct a study of the system’s physician leaders. (“Providence” is headquartered in Renton, Washington, and operates in Washington, Oregon, Alaska, California and Montana). The goal was to learn more about these executives through proven personality- and competency-based assessment methods.

The work would also serve as a foundation for continued research into physician leaders. For Providence, it was a chance to inform its strategies around physician leadership and to support the learning and development of its current physician leaders.

Other objectives shared by Witt/Kieffer, Hogan, and Providence included:

- Understanding the core leadership competencies of a group of physician leaders and how these competencies may help or hinder the ability to lead

- Comparing the leadership competencies of physician leaders vs. general healthcare leaders to improve leadership development efforts

- Developing tools and methodologies to help physician executives continue to grow as leaders

Takeaways:

- Research suggests certain characteristics and competencies of top-performing physician leaders.
- Organizations can now better evaluate physician leaders and how to leverage their talents.
II. Key Findings

Despite a modest sample size, several general conclusions can be drawn regarding the physician leaders who participated in this study:

1. Top-performing physician leaders tended to be more resilient, even-tempered and motivated by sharing success compared to good performers.

2. Higher scores on the competency report predicted higher patient loyalty.

3. When comparing top-performing physician leaders to general healthcare leaders, trends in the data suggest there may be personality- and values-based differences.

While this research can be considered exploratory, it represents a step toward understanding physician leaders and those factors that may differentiate top performers from good performers, and between physician leaders and general healthcare executives. Some of the qualities characteristic of top-performing physician leaders in the study appear in the graphic below.

![The High-Performing Physician Leader](image-url)
Conclusions and Implications for Physician Leadership

Through this research we have gained a better grasp of what characteristics and competencies define physician leaders at Providence, and separate good performers from top performers within that system. From the individuals studied, we can draw general conclusions about success-enabling factors for other physician leaders, and about connections between high-performing physician leaders and patient loyalty. This type of information can help Providence, as well as peer organizations, better evaluate current and prospective physician leaders and utilize their talents in conjunction with non-physician leaders.
What Recruiters Look for in a Physician Executive

By Debra Beaulieu, HealthLeaders Media, with Christine Mackey-Ross and Linda J. Komnick, Senior Partners and Practice Co-Leaders, Physician Integration & Leadership

As healthcare systems strive to improve outcomes and reduce costs amid the shift toward value-based care, more senior leadership positions are being occupied by physicians, nurses and other clinicians-turned-executives. For more insight into clinicians’ growing prevalence in the C-suite, I spoke with Linda J. Komnick, MHA, and Christine Mackey-Ross, RN, BSN, MBA, both with the Illinois-based executive search firm Witt/Kieffer. The following transcript has been edited for length and clarity.

**Takeaways:**
- Physician leaders are seen as catalysts in the transformation from volume to value.
- Top physician executives are expected to have the same business acumen as executive peers.

**HLM:** What are some of your general observations about this trend?

**Komnick:** We’ve seen a significant shift in executive leadership bringing a clinical voice to the table. Systems today are looking for physician leaders who understand the full continuum of care and how to optimize funds throughout the organization, managing risk. They’re really seen as the catalyst to guide the transformation we’re all experiencing of volume to value.

**Mackey-Ross:** They’re real executive jobs now. If you had a chair of a department 10 years ago, for example, that person’s emphasis was really programmatic on recruiting physicians, the research component, maybe the education component in a community hospital setting. But now, physicians
III.

are really in the thick of strategic decisions. They are expected to have the same business acumen as any other member of the leadership team.

**HLM:** Which is more significant: Health systems seeking leaders with clinical backgrounds or are more clinicians aspiring to lead?

**Mackey-Ross:** I think it’s both. When Linda and I started doing this, we could count probably fewer than 200 physician executives in the way that we’re talking about, with real portfolios of accountability. And my guess is that it’s probably in the thousands now. I would also guess that the largest-growing population of people attaining MBAs are probably physicians. We have also worked with a small number of physicians who went to medical school never really intending to practice in the traditional sense, but with the intent of being physician executives.

**Komnick:** In the past, physicians came up to these leadership roles more based on their clinical skills than their management experience.

**HLM:** So how important is it for aspiring leaders to get an MBA? What are the minimum requirements?

**Mackey-Ross:** The minimum requirements depend on the role for which you’re applying. Having an MBA will not get you the job, but it may help tip the scales. If I were advising a younger physician executive I would say to absolutely get it, as he or she would have a career limit without it, especially if aspiring to be a system CEO.

**Komnick:** I agree. Experience is always going to outweigh a piece of paper, but if you’ve got both, you’re on top. And the degree doesn’t have to be an MBA. I’m also a big fan of the MPH.

**HLM:** What does the supply and demand look like?

**Komnick:** There are so many organizations that are looking for these people. We used to have between eight and 10 candidates for these types of
positions, now I’d say we have three to five, and they’re each looking at two to three opportunities.

**HLM:** How specifically does an MBA or MPH help prepare a clinician for executive leadership?

**Mackey-Ross:** Typically, quantitative skills come very easily to physicians because they are used to analyzing data. The part that is a learning experience is the qualitative piece, which is how to work through others, how to delegate, how to redefine the meaning of team, how to build consensus, and how to manage a team. Those skills are developed well in the way most MBA programs are run, which is a team learning experience.

*Debra Beaulieu is the Senior Physicians Editor for HealthLeaders Media. Permission to reprint this article has been granted.*
The Global Market for U.S. Physician Executives Is Heating Up

By Christine Mackey-Ross, Senior Partner and Practice Co-Leader, Physician Integration & Leadership

The U.S. healthcare system has always been fairly insular. It has regulations and a reimbursement structure distinct from those in other nations, and certainly its own standards of care and quality. Its business model is driven by a strong private-public hybrid engine. For workers the money is good, especially for doctors, nurses and skilled employees; executives in the sector might not be on par with their corporate counterparts but they still do quite well for themselves. (Just ask a healthcare administrator in London, Mumbai or Hong Kong.) Because of this, healthcare executive talent in the U.S. has tended to stay in the U.S.

Traditionally there has not been much pull from abroad for healthcare executives either. Foreign countries presented the prospect of either a socialist (i.e., lower-paying) system or one that had few modern technologies and facilities. (Exceptions were predominantly in the Middle East, where the geopolitical situation and cultural restrictions gave many U.S. executives pause about relocating.) Going abroad in many cases was literally or nominally volunteer work.

In my recruiting work, however, I am seeing a shift in this dynamic. U.S. healthcare executives – particularly physician leaders – are looking more intently overseas for employment while the opportunities abroad proliferate.
– especially in Asia and the progressive areas of the Middle East. Healthcare borders are breaking down and the executive talent market is more global than it has ever been. There are more jobs than top candidates, pushing salaries and competition.

Why this change? One thing is that the healthcare marketplace is truly expanding and globalizing. While the EU has been pinched, and not all regions are increasing their healthcare spending, countries like India, China, South Korea, Japan, Singapore, Malaysia and the UAE are on the build. Developing nations are looking to “leapfrog” others.

Say what you will about healthcare reform in the U.S., but it is not an isolated phenomenon. Other nations (China in particular) are watching the U.S. market to see how hospitals and major health systems are addressing population health, slashing costs (or at least trying) while ramping up care quality, changing reimbursement structures, testing technologies and generally pursuing a more retail-flavored brand of medicine. As countries develop consumer-oriented models they are looking to partner with progressive U.S. providers and eyeing executives who are proven winners and change agents.

U.S. healthcare execs have a cachet that is unmatched. Physician executives – especially those who can serve as CEOs or chief medical officers – are particularly prized. They offer the prospect of respected credentials (typically an M.D. from a U.S. medical program), a clear understanding of operational best practices and an unwavering commitment to quality and excellence in care. When hospitals and health systems around the globe are looking for CEOs and other executives to help them to leapfrog or advance, physicians are strongly preferred.

Are U.S. physician executives interested? What would prompt, say, the CMO of a U.S. system to leave a good job for foreign shores? There are a number of factors at play: the complexity and uncertainty of the U.S. market; the chance to get in on the ground floor of a new or revamped venture and to be a bigger fish in a different pond; greater autonomy; a sense of mission; and
good salaries and perks. Many top U.S. executives are nearing retirement, are empty nesters and are looking for their next or last great career adventure. Many U.S.-based health systems are extending their reach abroad to expand their businesses and brands, creating the prospect of executives going overseas without changing employers.

**Can they go home again?**

A clear concern that U.S. executives have when considering going overseas is whether they can return again. This skepticism has diminished as U.S. organizations understand the benefits of recruiting executives with international experience. These individuals have a bigger-picture view, carry innovative ideas, and often have proven experience in building up programs and facilities from scratch. Physician executives are in great demand in this population health era, and with the improvement of healthcare facilities and infrastructure around the world there is no longer the stereotype that doctors lose executive or clinical skills when they work overseas – in many cases, in fact, they hone them.

There is great global demand for physician leaders from the U.S., and opportunities for these executives should continue to be plentiful and, increasingly, intriguing.
Why Doctors Make Good Healthcare CEOs

With Kimberly A. Smith, FACHE, Senior Partner

Do physicians make good CEOs, and what are the considerations around hiring a doctor to lead the entire organization? In the Q&A below, Kimberly Smith considers key issues.

There are more physician CEOs today than in years past. Are they generally successful, or do results vary significantly from one to another? What factors are at play?

Smith: I would say they are generally successful. There is some data – by researcher Amanda Goodall, for example – that suggests physician-led hospitals are more successful, but at this point it is still an assumption that needs proving.

Nevertheless, a physician CEO often makes sense for a hospital or health system. The key is ensuring that it is being done for the right reasons. Assuming that bringing on a physician CEO is a simple solution to fixing physician engagement and alignment issues is misguided. There are a number of times when we go into a project where there is discord among the medical staff over any number of issues. People see a physician CEO as a silver bullet for a whole lot of problems, which is much too simplistic. You have to get to the source of the problems. Additionally, a physician from outside isn’t always initially accepted by internal physicians, and so pinning great hopes on a physician CEO to fix everything simply isn’t wise.

Takeaways:

- A physician CEO shouldn’t be viewed as a “silver bullet” to fix all problems.
- Physician CEOs come to the role with some inherent strengths but also with a need to develop and hone skills.
V.

Assuming most physicians vying for CEO roles have less administrative and managerial experience in their backgrounds than non-physician candidates, is there a greater learning curve when they are hired?

**Smith:** There can be if that is the case. However, I am optimistic that there are more and more physicians who do in fact bring administrative experience to senior leadership roles. Physicians who are senior enough to be considered for CEO roles have to have come up through a role that gave them that exposure—for example, as a CMO or head of a service line or product line. They bring more administrative skills than many people give them credit for. As for a learning curve, by and large physician executives are really smart people and quick learners.

**What do physician CEOs do instinctively well?**

**Smith:** They have a laser focus on aspects of quality, outcomes, building clinical sophistication and competence. They tend to be growth-focused and strong proponents of developing other physician executives. Most come from a team perspective, having delivered team-based care for most of their careers, so valuing the contributions of all team members is an important part of their makeup.

**What do they struggle with or need to develop?**

**Smith:** Some come to the table with more financial skills than one might think as they’ve led large departments or service lines with substantial budgets. That’s not universally true, however. Government relations, lobbying, HR and marketing are other areas that they may understand intuitively but not have experience in. And they may not have had a lot of deep exposure to governance and the way boards work. The key is that the learning has got to be experiential—you have to live through that, but that’s true for any CEO. They’re going to have gaps in their portfolio of experience.
When a physician is chief executive, what are the implications for the rest of the leadership team? Do roles or reporting relationships change?

**Smith:** Differentiating a physician CEO from other senior physician leaders is important. There can be a tendency to take all issues that pertain to physicians to the CEO. Validating the role of executives such as the Chief Physician Executive or Chief Quality Officer is essential. The CEO cannot and should not be expected to weigh in on every single physician matter.

Finally, do CEOs who are MDs command higher salaries than non-physicians? Are the conditions of employment different in any other way?

**Smith:** Yes, in general. Our Witt/Kieffer data shows that physician CEOs command from 10 to 20 percent higher compensation than non-physician counterparts at small and large organizations. This has to do with the smaller pool of physician candidates, as well as the fact that CEOs must offset the drop in income from their clinical practices—the board will set its compensation philosophy based on market data. As noted above, it is just not possible for all CEOs to continue their clinical work even if they want to.
The Shifting World of AMC Deans and Department Chairs

With Karen E. Otto, Managing Partner and Practice Leader, Academic Medicine & Health Sciences

As academic medical centers feel more pressure to change and to serve students and communities in new ways, new types of leaders are needed. In this interview, Karen Otto considers the implications for AMCs and executive recruiting.

What's happening around the role of a typical clinical department chair or dean? Are the responsibilities of leadership expanding in scope and scale?

Otto: Deans and department chairs are increasingly expected to employ “systems-based thinking” when engaged in the 21st century academic medicine enterprise. They are expected to create clinical, education and research collaborations with community and regional organizations, and ironically some of these collaborations may be with historic competitors, especially within the clinical arena.

For example, with the formation of multi-hospital health systems with geographic reach, dean and chair roles can vary dramatically depending on whether the academic medical center is at the center of the new enterprise or one of many parts. With the latter, the clinical enterprise becomes managed at the system level of the organization, and the dean role may primarily provide...
oversight of the academic program only. Juxtaposed, when the academic medical center is the driver of the multi-hospital system, the dean and chairs have the opportunity to play a greater strategic role directing the clinical programs and outreach for patients and the communities the health system serves.

*Are skills changing, too?*

**Otto:** Yes. Deans and department chairs need to possess different management competencies than what was valued a generation ago. There is more to understand, for example, around the business aspects of the organization – the management of and strategy behind clinical community-outreach programs, for example. There is also a need for deans and chairs to reach beyond their traditional academic medical center footprint and to partner with entities outside of one’s own organization in order to achieve the tripartite mission of academic medicine. There is greater recognition that no medical school and department can operate in a silo.

*Deans and chairs are asked to lead the clinical, research and education missions of their institutions. Does this make recruiting them more difficult?*

**Otto:** Yes, historically universities looked for “triple threat” candidates – that is, those who have achieved success in research, managed complex clinical activities and have been considered outstanding educators. For those few that are accomplished in all three areas, they are in great demand. Most candidates are typically going to be focused on one area or the other, and unfortunately, strong educators are often not considered the highest value for most institutions.

The usual priority is research – it’s so hard to be a continuously funded investigator. The belief is that if you can recruit a dean or department chair who has been a significantly funded investigator with national standing, the institution or department’s overall reputation will rise sharply. As we know, however, what makes one successful in research may not always translate to success as a dean or department chair.
How are candidates gaining the expertise they need in budgeting and financing, innovation and partnering, fundraising, and other business elements that are critical to ensuring sustainability in the marketplace?

**Otto:** A lot of them are going back to school, getting advanced degrees such as MBAs or MPHs, or taking certification programs to enhance their management competencies. They get executive coaches and get specific help in specific areas such as personnel management, communication skills and conflict resolution strategies. It’s also not unusual for a dean to have an associate dean or chief administrative officer who is the point person on some of these things. It’s understood that the business skills of these positions aren’t developed overnight.

*From a recruiting standpoint, what will be the greatest challenges in searches for chairs and deans going forward?*

**Otto:** Ideally you would like candidates who present the broadest understanding and experience in research, clinical service and medical education. But quite frankly the art of search is to be able to match the capabilities of the candidate to the institution’s needs, aspirations and culture. In the end, leadership character, empathy and evoking the joy of academic medicine predict long-term success for a successful dean or department chair.
Toward a New Brand of Faculty Practice Leadership

With Elizabeth B. Frye, MD, FACP, Of Counsel

Movement in healthcare and academic medicine towards improved quality and new cost structures, organizational consolidation and alignment, and clinical integration have resulted in an evolution of faculty practice plan leadership. In the following Q&A, Elizabeth Frye 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, definitely. There are two major challenges that we are seeing. One is that faculty practice plans are trying to evolve into truly 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 – for improvements in efficiency, care quality and financial performance. The challenge is, how do you group-think while at the same time make sure your department is flourishing? Secondly, these practices need to better align with their hospital/system partners so that there is joint recruitment, joint programmatic growth and mutual benefit from improved bottom lines and success.

Takeaways:

- Faculty practice plans are trying to evolve into truly multi-specialty group practices.
- The leader must be able to move from strategy to implementation and have comfort in a matrix environment.
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. This might mean, for example, that 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 skill needed, with the movement toward increased quality, bundled payments, etc., is an ability to utilize big data from multiple data sources including financial data, medical records, quality data and outcome data, 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 in working in a matrix environment where leadership is consensus-driven and not authoritarian. It’s a more holistic style of leadership than in the past and there are not a lot of people with experience that is this broad.

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

**Frye:** If that person has not had direct experience, yes. The first learning challenge is, how do you relate to the interpersonal competencies needed to succeed in this unique environment, the need to build strong relationships with department leaders and hospital leaders, and to look for commonalities to advance the total mission? For a new practice leader, this means learning about colleagues and how you can best work with them.

There is also a real 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 the group leader to focus on optimizing performance.
A third challenge is the move to population health that has come about in the past decade. For instance, how do you define your “population”? In many AMCs, patients are referred so that can add complexity to running a practice that already is adapting to a more patient-focused, value-based environment.

*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. If you put in an EHR, you get to see first-hand how it works or doesn’t work. Nevertheless, the responsibilities of running a faculty practice plan usually outweigh the benefits of staying clinically active. Some physician leaders, however, still try to keep clinically active in order to maintain their 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, as I’ve noted, hard to find and can pretty much go wherever they want. They’re in the driver’s seat. As recruiters, we understand that faculty practice plans are in flux. We know the ideal candidate has to be a person who enjoys building new things and innovating. It has to be someone who is comfortable taking on a new career challenge.

Despite the recruiting challenges, I am optimistic. Times of change and flux are an opportunity to have something better than what you have. Therefore, I see faculty practice plan leadership continuing to evolve for the better.
The Emergence of the Chief Health Information Officer

By Hillary Ross, JD, Principal, Managing Director, IT Practice Leader

There is a definite trend toward new executive titles, roles and responsibilities as the modern healthcare system evolves. The chief health information officer (CHIO) is one of these titles, stemming from the chief medical information officer (CMIO) role as it changes from a purely operational position into one that includes strategy, transformation and leadership over teams.

It’s a process of role expansion that we’ve seen in health IT recruiting over the past few years—for example, the director of analytics has become the chief analytics officer, the director of technology services has become the chief technology officer, and the director of is security has become a chief information security officer. What distinguishes the role of CHIO is an increase in scope and that the role has undergone a transformation from being a key IT leader to one of the top physician executives within large and progressive organizations.

Many of our clients started developing the CMIO role as the market changed in the past two decades, and they came to the realization that clinical input was necessary in order to ensure alignment between physicians, nurses, IT, finance and operations. Those initial CMIOs were essentially “super-users,” or technologically-inclined physicians that may have progressed into clinical

Takeaways:

- The CHIO role is evolving from the more operational CMIO to a broad, strategic senior leadership position.
- CHIOs must be visionaries who utilize technology and data science to transform healthcare.

Recruiting and Developing Physician Leaders
IS. The first CMIOs that were recruited for health systems were liaisons and translators between the clinical and technical staff, acting as an imperative bridge between the chasms that could often exist between the departments. The implementation of EHRs accelerated the need for this role to the point that most complex hospitals and health systems now have a CMIO.

**CHIO Responsibilities**

As many health systems have completed the implementation of EHRs, the focus now has shifted again to the areas of optimization, analytics, security, ACOs and data exchanges. The responsibilities of the CMIO have significantly increased given the evolution of the role. With fee-for-value, health systems now see a need for a unified clinical and IT strategy that can then be implemented throughout a health system. This is where the chief health information officer becomes a critical cog in an innovative and sophisticated healthcare system.

The CHIO may well still be the liaison between the clinical and IT staff, but more importantly it is the clinical strategist that can be looked at to guide a health system’s vision to move forward with the transition to fee-for-value. Most CHIOs not only have a deep understanding of technology but also appreciate how to leverage ROI to take their health system where it needs to go. More than that, they are executives that are able to present their vision to the C-Suite and the Board of Directors and provide the path for implementation.

A CHIO must be a very high-level visionary able to understand the interactions between the complex areas within a health system including everything from operations, analytics, research, informatics, finance and IT. A CHIO will likely have control of large clinical or medical informatics teams that include analysts, technologists and informaticians. CHIOs might also now have CMIOs that report to them, especially in the most complex of systems. With this structure, the CHIO is able to focus on the high-level work around strategy while trusting a team of CMIOs and medical directors to implement that plan. In some cases, the strong CHIO may well have the chief information
officer and entire IT organization reporting to them, although this is still somewhat rare in the market.

From our clients, we see that the CHIOs exist in the most progressive organizations that have an EHR fully implemented and have a well-established IT organization. Most organizations that utilize the CHIO title are well into EHR optimization, transformation and data science initiatives. The CHIO must be able to provide prioritization that will yield the most benefit in terms of improving patient care, making resource utilization more efficient, and moving forward strong initiatives for population health.

[A previous version of this article was originally published on HealthSystemCIO. Permission to reprint has been granted.]
Physician executive jobs are plentiful, and yet despite this high demand there is a small pool of physician leaders with the experience and skills required to succeed in various executive positions. A vacuum waits to be filled by doctors who can develop the appropriate characteristics and resumé to thrive in this environment.

The good news is that the leap that physicians must take into executive roles is not as great as they might think. Potential physician leaders encounter a multitude of opportunities, some of which do not require additional schooling or certification. Stepping into these new roles can be done quickly and successfully.

Would-be physician executives can take note of a few trends and observations that I hear about as I speak to other physician leaders in various roles and organizations. These include:

**Physicians are ready for leadership.** They are intrinsically fast learners, are extremely outcome-driven, and have high expectations and an unparalleled work ethic. They are comfortable with responsibility and decision making. In other words, they already have executive leadership skills. These attributes have made them successful in solo practices or small team environments, and can be leveraged for success in the executive suite.
Leadership opportunities exist within one’s own organization. The journey to a major leadership role begins within your current workplace. While formal physician leadership roles in hospitals and health systems can be limited, there are often informal paths that can be taken. Physicians who see themselves as up-and-coming leaders need to put themselves in positions of strength to effect measurable change. Good places to seek this out are the organization’s quality committee, process improvement committee, serving on the Board of an ACO, assisting with the development and growth of a clinically integrated network, or pharmaceutical and therapeutic committee. Participation in these informal roles is an outstanding way to become exposed to the dynamics of organizational politics, budgeting, operational best practices and dealing with different personalities.

Initiating a leadership role can go a long way. Taking the lead on project-based initiatives—such as spearheading EMR implementation, helping to develop a more clinically integrated delivery system or working with leadership on process improvement activities—provides valuable experience. Physicians should also visit the American Association for Physician Leadership (www.physicianleaders.org) and consider becoming a Certified Physician Executive (CPE) as another avenue to gain leadership experience and enhance their resumés.

It helps to develop “softer” skills along the way. There is no magic formula when it comes to outstanding leadership, but there are some skills, such as collaboration and communication, which can help tremendously as you grow in your role. As the industry and the customer base demand more integration between departments and enterprises, so will our physician leaders. After all, team-based healthcare delivery is known for its consistently high quality. Two cornerstones of integration are communication and collaboration.

Collaboration is earning employee engagement and buy-in through influence, not through a direct reporting relationship. Collaborative healthcare is not “my way or the highway”; rather, the approach is more, “let’s all sit down at the table and see how we can work together to solve this problem.” A physician involved in committee work gains exposure to different personalities,
specialties, departments and experiences, and learns to be empathetic to
differences and sympathetic to similarities with their colleagues.

Communication is a skill that we all have developed throughout our lives
and yet we all can improve upon. It is imperative for leaders to listen to,
educate and set clear expectations for other members of the team. The
aforementioned informal leadership roles can help physicians enhance their
communication skills before hitting the big stage.
Physician leadership roles come in many shapes and sizes, from the more traditional vice president of medical affairs and chief medical officer to the more modern chief clinical officer. While there is no defined path to securing positions like these, there are some concrete steps to take to increase a physician’s competitiveness as a leadership candidate, as healthcare systems increasingly look to incorporate physicians into the C-suite. As a note, the assumption by healthcare organizations assessing candidates for physician executive roles is that a potential candidate is a high-quality clinician. So, candidates must take additional steps to differentiate themselves from their peers.

- **Get involved with hospital committees.** Hospitals of all sizes typically have a variety of committees on which members of the medical staff can sit. Whether it is the pharmacy and therapeutics committee, the quality committee, peer review committee, or informatics committee, participation will provide exposure to the inner workings of the hospital.

- **Become a leader on the medical staff.** Many times, medical staff leadership positions are elected positions. Sitting on hospital committees and volunteering to lead initiatives creates visibility and shows leadership. This type of engagement many times organically leads to the opportunity to take on defined leadership roles within the medical staff.
• **Appreciate the importance of quality and process improvement.** Hospitals and healthcare systems are finding that they can achieve two of the three points of the “Triple Aim” by improving standardization of care practices and reducing variation. Physician executive candidates with training in process improvement methodologies such as Lean and Six Sigma are becoming more and more attractive. Similarly, demonstrating an understanding of clinical information systems and the role of IT in healthcare is important.

• **Get involved in professional organizations.** Organizations such as the American Association of Physician Leaders (AAPL) and the American College of Healthcare Executives (ACHE) can expose physicians to additional education on what is going on in healthcare across the country, and can provide incredible networking opportunities.

• **Obtain advanced degrees and certifications.** Physician executive roles are becoming more and more strategic, and it is becoming essential for candidates to demonstrate their financial and operational proficiency. An MBA, MHA or equivalent degree is a differentiator. Credentials such as Certified Physician Executive (CPE) and Fellow of the American College of Healthcare Executives (FACHE) are becoming more prevalent as well.

• **Stay up to date on any clinical and board certifications.** For a physician executive, credibility is key – it is what separates a chief physician executive from those in the C-suite without medical degrees.

• **Write a business resumé.** The most important questions to answer on a business resumé are: “Where did you work? When did you work there? What did you accomplish during your time there?” Remember to quantify accomplishments. For instance, writing about leading an initiative that resulted in a reduction in length of stay is significantly less effective than specifying by how much length of stay reduced as a result of the initiative.
• **Do not job hop.** Nothing turns off potential employers like the fear of having to fill the same position a year from now. A demonstrated commitment to a job and organization goes a long way.

• **Reach out to an executive recruiter.** Build a relationship with an executive recruiter before you need them. Hospitals and health systems often partner with executive search firms in their search to fill physician executive positions. A recruiter will be able to articulately explain the typical recruitment process and answer questions. As these search firms are typically retained by the hospitals and health systems, there will be no financial obligation to candidates seeking general advice.
Physician Leaders Must Think Hard about Soft Skills

By Linda J. Komnick, Senior Partner and Practice Co-Leader, Physician Integration & Leadership

Physicians are often considered natural born leaders, as medical training historically has required autonomy and focused on the needs of “one captain” of the ship. Yet few work in broad leadership positions in which they oversee more than a few staff or tackle major administrative projects. This is a dilemma as new healthcare models require not only changes in the autonomous physician-driven care model but also transformational physician leaders to guide and ensure alignment for optimized clinical outcomes, better productivity, sustainable growth across the continuum of care and other strategic priorities. I see more physicians looking to get into administration – some even straight out of medical school – but the sheer need is greater than the interest so far.

The result can be that “an individual who has not been well prepared to lead is thrust into a very challenging leadership situation,” said a recent Mayo Clinic report. In our senior executive recruitments, we have fewer qualified candidates for given positions compared to even a few years ago.

To solve this problem more physicians need opportunities and encouragement to bridge into administration, whether they are pursuing roles as medical directors, heads of group practices, service line chiefs and so on. Many hospitals and health systems understand this and have started their own

Takeaways:

- Emerging physician leaders can develop soft skills through formal and informal channels.
- Executives with clinical expertise and hard and soft administrative and leadership skills are in great demand.
physician leadership academies and training programs. There are also of course MBA, MMM (Master of Medical Management) and other relevant graduate programs, while medical schools are providing more business and management training for students and residents.

What are health systems and other employers – and the recruiters working for them – considering to signal readiness? It has more to do with the display of a variety of hard and soft leadership skills, and a pattern of development and career progression. Perhaps the most asked-for skills that I see in job descriptions for physician leaders are soft skills such as emotional intelligence (values, self-awareness), communicativeness and interpersonal skills, collaborativeness and empathy.

Some physicians are naturally gifted with softer leadership qualities, but like almost anything there is a learning and development component. What steps should emerging physician leaders take?

1. **Leverage self assessment.** Assessment methodologies are becoming increasingly used by employers and executive search consultants to gauge the capabilities of potential hires, as well as their suitability to a given position. Aspiring physician leaders should seek such assessments out themselves, or take advantage of them when requested, simply as a means of knowing themselves better.

2. **Seek out committee leadership.** Doctors are used to and expected to make quick, confident decisions, either by themselves or with a closely defined group of colleagues (eg, peers and nursing staff). Committee work can introduce physicians to a broader, more consensus-driven environment.

3. **Embrace coaching.** Many executives in the corporate world owe their success to coaching. While coaching can serve many purposes, most of all it gives an up-and-coming executive an objective consultant to bounce ideas off of and confide in.
4. **Explore mentoring.** Mentoring can take many forms. It is akin to coaching but from a peer or colleague whom one trusts. For aspiring physician executives, a mentor could be a more senior administrator (physician or not). And it could be someone internal or external to one’s organization.

5. **Leverage search consultants.** Executive search consultants can provide honest input to physician executive candidates on their merits for career advancement. This includes the soft skills. We can also provide constructive criticism and advice to candidates in the name of supporting their careers.

Qualified physician leaders are in short supply and great demand. Those executives with the full complement of experience, clinical expertise and hard and soft administrative and leadership skills can chart their own career advancement.

*[An earlier version of this article was first published on Physician’s Weekly on March 7, 2017. Permission to reprint has been granted.]*
How to Be Smart and Savvy in a Leadership Interview

By Sue A. LeGrand, Senior Associate

The demand for physician leaders remains high as institutions continue to recognize the need for individuals to guide their organizations through today’s ever-changing healthcare landscape. Despite fierce competition for qualified candidates, a strong clinical background and impressive educational résumé aren’t enough to secure a position. Even the most sought-after candidates still have to shine in the interview, a setting somewhat unfamiliar to many physicians.

Unlike the emergent situations physicians handle on a daily basis, the interview is an event that affords the luxury of preparation. In my experience, it is thorough preparation that makes the difference when candidates vie for the same position. The following is a “to-do” list for physicians who wish to be savvy interviewers.

The key thing: the interview is not all about you and your expertise. It’s about “we” and how your skills, values and passion will align with what the organization seeks in its executives.

1. **Do your reading homework.** Carefully read the information supplied by the search firm and the client to learn about the position. Then take the time to search for additional information and news about the client and the market in which they compete. As you read, begin to think about how

**Takeaways:**
- Preparation is critical to ensure a candidate shines in the interview.
- The interview hinges on how skills, values and passion align with the organization.
your background and skills fit the position they are seeking to fill, and how you can help the organization meet the goals they have set and address challenges they face.

2. **Anticipate the questions you will be asked and prepare answers to those questions.** In general, a concise answer is preferable to a lengthy one. Not only is a shorter answer easier for an interviewer to understand, it gives the interviewer a chance to ask follow up questions and take the conversation in the specific direction they want to go. Take the opportunity to demonstrate humility in your answers by recognizing the contributions of others in your past successes.

3. **Make a list of the questions you want to ask,** about the position, the organization, the community or anything else that you need or want to know. Your questions will demonstrate your knowledge of the organization along with a desire to learn more, as well as your interest in becoming part of the leadership team.

4. **Identify instances where you have demonstrated leadership, and be ready to talk about them.** Physician leadership involves influencing, advocating and facilitating change. The skills used to manage a patient crisis are not necessarily the skills you need to demonstrate during the interview. Most interviewers will assume that you know how to take charge and instruct in a clinical setting. They need to understand how you have been able to use “softer skills” to effect change.

5. **Know who will be interviewing you.** This will allow you to make personal connections during the interview. Though you will have the chance to get to know them better in the future, showing a sincere personal interest in those interviewing you, regardless of their job title or position in the organization, will make a positive and lasting impression.

6. **Carefully evaluate your own strengths and weaknesses.** Be ready to go beyond what appears on your resumé, your degrees and your title,
and describe specific examples of your leadership skills and results. Being able to recognize areas where your skills need development is not an admission of failure, but rather a sign of self-awareness.

7. **Dress the part.** Dress and accessorize conservatively, and don’t overdo the scents, makeup or styling products. Your appearance is not what you want people to remember about you.

8. **Be conservative in your behavior and comments.** What you say may spread throughout the organization. It probably goes without saying, but politics, religion and sex are not fodder for discussion on interview day.

9. **Take a deep breath, be confident** – you are a strong candidate or you wouldn’t be here – and be your best self.

The interview is the chance for you to secure the offer and take the next step in your career as a physician leader. With the right preparation, that future is yours.
Physician Executives: A Resumé Can Make the Difference

By Stephen C. Davis, Consultant

I have participated in many physician CEO and physician executive recruitments recently, and quite often applicants who relied on a traditional CV to communicate their qualifications for the position didn’t come across as physician leaders. Though we receive many robust and impressive CVs detailing a candidate’s education, administrative titles and clinical, research and teaching credentials, we aren’t always able to determine what leadership impact—to market share, operations, quality, clinical outcomes and financials—the candidate had made throughout his or her career.

These experiences confirm my long-held belief that aspiring physician leaders need to take a lesson from the business world and fortify their CVs with executive resumés when they compete for healthcare leadership positions.

**Takeaways:**

- Physicians should supplement a CV with a carefully constructed business-style resumé.
- A resumé “sells” the candidate’s leadership, strategy and operational experience.

**How A Resumé Differs from a CV**

A CV typically includes only a chronology of a candidate’s vital statistics. It is a list of accomplishments, without context or quantification. It assumes the reader will know the complexity in size and scope of the organizations where the candidate worked previously, and will understand the responsibilities held by the candidate based on the job titles listed.

A resumé doesn’t make the same assumptions about the reader. It includes details about a candidate’s career and the responsibilities held throughout.
It is written to convince the reader that a candidate is able to perform the duties of a position and, more important, solve the specific problems or meet the challenges the hiring organization faces. The résumé is the document that most organizations will rely upon to discern what a candidate can do for them.

Why It’s Important to Have a Résumé

Enhancing a CV with a carefully constructed résumé is becoming increasingly important as ambulatory and outpatient arenas grow in importance for healthcare organizations, and physicians are sought to fill leadership positions in these institutions. To capitalize on the growing demand for physician leaders throughout healthcare, physicians should be ready to interview for leadership positions, and that begins with knowing how to prepare a strong executive résumé.

Best Practices to Follow

An effective executive résumé should “sell” the leadership, strategy and operational experience of a physician executive. The structure of the résumé is important, and generally includes the following sections:

- The **Professional Summary** highlights the candidate’s qualifications for the job. In a short paragraph, it provides the reader a synopsis of the candidate’s professional qualifications. The professional summary often includes a list of a candidate’s core competencies related to the position sought. For example:

  **Accomplished Medical Executive**

  A collaborative, strategic Chief Medical Officer of an integrated healthcare system, with superior business skills and experience. Committed to safe, high-quality healthcare and champion of XYZ’s pursuit of a High Reliability Organization (HRO). Built and managed a highly successful practice with 13 physicians and 26 CRNA’s. Effective contract negotiation skills have
resulted in over $20MM savings to XYZ. Board certified in both Internal Medicine and Anesthesiology with 30 years of clinical experience.

**Core Competencies**

- Bullet 1
- Bullet 2
- Bullet 3

- **Professional Experience** details the work history of the candidate. Each entry includes (1) the organization name, location and a brief description of organization size and scope, (2) title, dates held and brief summary of roles and responsibilities, (3) bulleted list of operational and strategic accomplishments. Continuing the example above:

  **XYZ Healthcare, City, State**
  
  *XYZ is an integrated healthcare system with 2 acute care hospitals, a heart institute, home care and long term care. XYZ, in city, state, is a 310-bed facility and XYZ, in city, state, is a 146-bed hospital.*

  **Chief Medical Officer, 2013-Present**

  *Paragraph on roles and responsibilities of the position.*

  - Accomplishment 1
  - Accomplishment 2
  - Accomplishment 3

  Be sure to use real numbers and statistics to quantify your accomplishments, including the details about the size of departments and teams you managed, the budget you controlled, the savings you created, your P&L contribution and changes in rankings you influenced. These details improve the strength of your resumé.
- **Educational & Board Certification** provides a list of degrees granted and certifications awarded, as illustrated below.

<table>
<thead>
<tr>
<th>Degree, University, City, State, Date</th>
<th>Certification, Certified date</th>
</tr>
</thead>
</table>

These are some of the basics. Though very important, a resumé doesn’t eliminate the need for a CV. A CV should still be a part of a candidate’s presentation package, but the addition of a carefully written resumé will boost an aspiring physician executive to the next level.
Contact Our Authors

Practice Leaders

Linda J. Komnick  
Senior Partner and Practice Co-Leader, Physician Integration & Leadership  
lindak@wittkieffer.com

Christine Mackey-Ross  
Senior Partner and Practice Co-Leader, Physician Integration & Leadership  
chrismr@wittkieffer.com

Other Contributors

Stephen C. Davis  
Consultant  
sdavis@wittkieffer.com

Karen E. Otto  
Managing Partner and Practice Leader, Academic Medicine & Health Sciences  
kareno@wittkieffer.com

Daniel Dimenstein  
Associate  
ddimenstein@wittkieffer.com

Jason P. Petros  
Consultant  
jasonp@wittkieffer.com

Elizabeth B. Frye, MD, FACP  
Of Counsel  
efrye@wittkieffer.com

Hillary Ross, JD  
Principal, Managing Director, IT Practice Leader  
hross@wittkieffer.com

Sue A. LeGrand  
Senior Associate  
slegrand@wittkieffer.com

Kimberly A. Smith, FACHE  
Senior Partner  
ksmith@wittkieffer.com

Richard Metheny  
Practice Leader, Leadership Solutions  
rmetheny@wittkieffer.com
About Witt/Kieffer

Witt/Kieffer is the nation’s preeminent executive search firm supporting organizations improving the quality of life, including those in healthcare, education, academic medicine, life sciences, sports and the not-for-profit sector. It also serves clients through its Board Services, Information Technology and Leadership Solutions practices, which offer services that further strengthen client enterprises.

About the Physician Integration and Leadership Team

Witt/Kieffer has an impressive track record in finding experienced chief medical officers, chief clinical officers, clinical department chairs, medical directors, and other physician leaders. Our search professionals with clinical and/or administrative backgrounds appreciate what healthcare organizations need in more traditional physician leadership roles as well as leaders in integrated and independent group practices. We also stay connected with emerging physician leaders as healthcare organizations increasingly tap physicians for CEO roles.

For more information, visit wittkieffer.com.

Copyright Witt/Kieffer 2017