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2011 ACPE Leadership Roundtable

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Introduction

Physician executives are essential to today's health care leadership teams who are working toward accountability, streamlining care and aligning stakeholder interests. Physicians are increasingly called upon to integrate clinical insight with business skills to help lead their organizations.

As more physicians chart their paths toward a challenging, yet rewarding, career in health care administration, the Cejka Executive Search and ACPE Physician Executive Compensation Survey explores the key trends and factors that drive physician executive compensation and the latest developments in physician executive leadership.

At the 2011 Fall Institute of the American College of Physician Executives (ACPE), Paul Esselman, of Cejka Executive Search, convened a panel of four distinguished physician executives to explore the continuing challenges, emerging opportunities, roles and incentives that are part of a physician leader's world today.

The 2011 ACPE Leadership Roundtable

Mr. Esselman: The overall increase in physician executive compensation represents a 5.9% two year gain from our 2009 survey, well below the previous 11.2% two year increase. This also represents the lowest rate of increase since 2001. Broken down, you see that the CEO and president saw a 2.3% increase in the last two years and the CMO saw a 5.5% increase. For the last 10 years, however, this represents a 45.2% increase and we have seen the value of physician leadership in health care organizations truly start to be recognized in the last decade.

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A major subject in this survey and one our panel will weigh in on, is whether a post-graduate business degree is essential for physician executives to remain competitive. Almost 90% of our survey respondents said they absolutely believe that the training of our physician leaders needs to change and continue to evolve to meet the growing demands of our organizations. About 65% say that their current organization supports some sort of physician training program.

We'll also discuss the process for bonus compensation – this year's survey reveals that margin pressure, reduced volumes and public scrutiny are driving down physician executive bonus compensation. Increased pressure on financial performance and the risk/reward compensation profile for physician CEOs and CMOs has been a factor in keeping compensation growth levels down since 2009.

With that, I will introduce our distinguished panel and thank them for joining us and engaging in this conversation:

- **Dr. John L. Boyd, III**, Chief Executive Officer and Chief Medical Officer, Scott & White Children's Hospitals and Clinics
- **Dr. Ben H. Brouhard**, Senior Vice President, Senior Search Consultant, Cejka Executive Search; Former Executive Director, Women's & Children's Service Line and Associate Chief Medical Officer of Education, MetroHealth Medical Center
- **Dr. Tammy Lundstrom**, Former Chief Medical Officer, Providence and Providence Park Hospitals; Associate Professor of Medicine and Adjunct Professor of Law, Wayne State University
- **Dr. Michael Patmas**, Chief Medical Officer, Woodland Healthcare

What market and industry realities are driving these trends in physician executive compensation?

Dr. Lundstrom: I think that the economic conditions, if you look at what you describe for an average clinician, mirrors what is happening in the executive world. There's a lot of discomfort about salaries for executives, which is probably influencing the change. Certainly, economic downturns and decreasing reimbursement are also influencing the change.

Dr. Patmas: The coming of value-based purchasing, accountable care, and the need to deliver a better clinical value proposition are the driving forces behind physician and clinical integration. Increasingly, health care systems recognize that without effective physician leaders, clinical integration and physician integration is not possible.

Dr. Patmas:
The coming of value-based purchasing, accountable care, and the need to deliver a better clinical value proposition are the driving force behind physician and clinical integration.

Dr. Boyd: Specifically talking about compensation, every executive role had an "at risk" part of their salary. With the economic times changing and the results in many organizations not being what their financial metrics needed, the bonus gates couldn't open up. Many of our colleagues had not received that "at risk" part in their salary so that plays a role as well where in the previous four years, I don't think it did.

What is your process for determining bonus compensation for your organization's key physician leadership?

Dr. Boyd: Generally speaking, my experience is that we would love for them to be based on quality, patient safety and patient satisfaction. However, you still have to have the financial pull of resources to pay out the bonuses. So my experience has been that there is a financial gate that the organization has to meet. Then the larger percentage of the bonus would be related to your achievements in quality, patient safety, patient satisfaction, and also the budget you oversaw.

Dr. Brouhard: Generally, I can speak for MetroHealth. MetroHealth is a safety net organization, so we have a little more financial constraint than some other organizations. Basically what we do with department chairs is comp analysis. Every three months, we divide up everybody's pay into clinical research, education and administration and we look at those. The clinical is based on RVU's. The administrative, which is really what we're talking about, is largely based on where they are within the organization. The higher they are in the C-suite, the more they're dependent upon how the organization does. But as John pointed out, if the organization is not doing well, the extent of that bonus is not going to be given out.

Dr. Lundstrom: The organization that I most recently worked at required most of the bonus to be about quality, patient safety and teamwork, but there was a financial bar. If you were not at the financial bar and didn't hit the finances, then there was no opportunity for bonus. If you hit the finances, then the percentage opportunity was split between the quality, teamwork and safety.

Dr. Patmas: What you typically find is base compensation with 20-30% bonus potential, based upon targets that will be set, in my case, at the corporate level and then other targets that are set locally and negotiated with the CEO at the local level. It's a mixture of corporate and local targets that would represent as much as a third of the compensation.

Mr. Esselman: I'd like to go off our question a little bit and pose a correlating question, because it's one of the challenges we see with a lot of physicians who want to take leadership positions, but they're in more of the highly compensated specialties. They want to get more into leadership or management positions and all of a sudden, they go from what they're clinically making to fitting into the pay structure of the C-suite team or the management

team. I'm curious from a practical perspective, how you deal with individuals making that transition or do you see physicians pull away from that leadership path because of that?

Dr. Patmas: That transition from physician to executive is long and arduous and not simple. One of the adjustments that one has to make is becoming comfortable with "at risk" compensation. The higher up you go, the more you will find that your compensation is tied to your performance.

Dr. Lundstrom: It is difficult for the very high income specialties to understand that administrative salaries are probably never going to achieve what the full clinical salary could for some very, very high paying specialties. Depending on what the specialty is, even in the lower paying specialties, it's something that you really have to love. It's really got to be a passion because it's hard work and it's difficult.

Dr. Lundstrom:
The organization that I most recently worked at required most of the bonus to be about quality, patient safety and teamwork, but there was a financial bar. If you were not at the financial bar and didn't hit the finances, then there was no opportunity for bonus.

Dr. Boyd: That's actually one of the first questions I asked a friend of mine who is a cardiac surgeon. Can you live on a salary that's about half of what your making, if not less than that? He had actually put some thought into it and felt that because he did have this passion and desire, that's the way he wanted to take his career so he was willing to do that. The uncertainty of not knowing exactly what that year-end number is going to be bothers some folks, but it can also speak to our competitiveness. If I hit the ball out of the park, then I'm going to do very, very well. If I get a single, I'll get paid like a guy that hits singles.

Mr. Esselman: We did track the bonus component of physician executive salaries on our survey and found that bonuses are based upon achieving a mix of 51% organizational goals and 49% personal goals, so it is heavily weighted to how the organization does. For CEOs, bonus goals actually kick up to 61% for organizational goals and 39% for the personal goals, so there is more risk as you go along.

Is a post-graduate degree essential for physician executives to remain competitive in today's health care environment? Is it a requirement in your organization?

Dr. Brouhard: Generally, it's not a requirement, although it may be a requirement for some, perhaps larger, organizations, such as multi-hospital organizations. There needs to be a distinction between the requirement for that master's degree, that advance training, versus the sufficiency of it. At Metro, we often support the attainment of the degree. Where we fall down, at least from what I've seen, is when we don't support that person well enough to make sure they're ready to go in and take on an administrative role when they have that degree. That's critically important as these people go through and say, I want to do this. I want to take the pay cut. They have to be mentored. They have to be given the opportunity to use that degree and use their knowledge. Certainly, if an advanced business degree is a requirement, it's not sufficient.

Dr. Boyd: It's not a requirement, but it's becoming more and more common that the organization will look for people with advanced degrees. There wasn't one thing in my MBA that taught me how to be a chief medical officer. It was a ticket that I needed to have to be considered as a CEO. The most important things that I learned in my career were through leadership experience. I think some of the leadership courses that are taught at the ACPE are very good and it's working with mentors, giving me the opportunity to advance slowly in my arduous journey to become a physician executive. I look back on my MBA: It taught me how to read a balance sheet. It taught me a little bit about strategy and marketing management. But it really did not teach me how to be a chief medical officer when I had two department chairmen in my office screaming at each other.

Dr. Lundstrom: The reflection of what the additional skill sets are all about, teamwork and leadership, are highly important to train and be educated in. Generally the degree is preferred, but requisite training and experience will trump a degree. Those skills are going to help with the physician integration, are important for the future, and are the skills employers will be looking for.

Dr. Boyd:
There wasn't one thing in my MBA that taught me how to be a chief medical officer. It was a ticket that I needed to have to be considered as a CEO. The most important things that I learned in my career were through leadership experience.

Dr. Patmas: I'll take a slightly different stance. Within Catholic Healthcare West there are a number of physician executives working as VPMA's or physician advisors who don't have graduate degrees. As you look upward to the CMO role or the senior vice president role, the management or master's degree is going to be more important. I would encourage those of you who are interested in moving into management and pursuing a career path to strongly consider a master's degree in management. It adds to your credibility and really deepens your understanding of what goes on within an organization. I would point out that the master's degree by itself doesn't guarantee success. There is a lot that goes into transitioning from the culture of medicine to the culture of management. They are two very different worlds and you have to understand that to really be successful.

Mr. Esselman: In the survey, CMOs reported double digit differences in total compensation with post graduate management degrees versus those without an MBA and MMM. There is a pretty significant difference so we'll have to watch how that evolves over the next two years. We'll be back in two years talking about an update on the compensation trends.

What are your thoughts on physician leaders maintaining a clinical practice?

Dr. Boyd: I currently don't. Up to two years ago, I did some clinical practice. I do not think it's necessary. I've been in pediatrics more than 30 years. I've done a few things in those years that clinically, I'm very proud of. Because I'm at a teaching institution I do grand rounds. Hopefully I make meaningful comments; we'll let the residents and the students determine that. I think you've proven yourself as a clinician before you step into this role. It is not required in my organization that I practice. I just opened a new children's hospital over the last two years and I could not have effectively practiced any clinical medicine.

Dr. Brouhard:
It depends on the specialty and scope you have. If you have a multi-hospital organization it becomes very difficult to practice. In my role, it's one hospital system and I'm the only pediatric nephrologist so I either had to farm it out or I had to do it myself, so I did it.

Dr. Brouhard: It depends on the specialty and scope you have. If you have a multi-hospital organization it becomes very difficult to practice. In my role, it's one hospital system and I'm the only pediatric nephrologist so I either had to farm it out or I had to do it myself, so I did it. It does have some credibility with the residents and with the faculty when you're on call, they call you and you come in and see the patient. Our current CMO is an intensivist. He's an adult pulmonologist in critical care and he tried desperately to be on service two weeks every six months. It was a nightmare for him. It was a nightmare for the faculty because they couldn't get to see him and now he's gone to weekends. It's really not very tenable. That's why I think it makes a difference on the organization, your scope, and again, what kind of practice you have.

Dr. Patmas: Early on in the career path, it's reasonable to maintain some clinical practice, particularly if you're still younger. As you move up it becomes increasingly impractical to try to maintain a clinical practice. For those for

whom clinical practice is an essential part of who you are, bear in mind that might make it unpleasant for you to continue toward management because you'll be pulled away from clinical practice. For the younger physician, it's a good idea, but as you move up, you almost certainly will have to let go of clinical practice at some point.

Mr. Esselman: Sixty-eight percent of our respondents report that they continue to practice medicine. Forty-five percent of our respondents report that clinical hours are a requirement for their position. For our own research engagements about 50% of the organizations say their leader has to maintain at least 10% clinical practice.

What factors most commonly "derail" a physician from his or her leadership career path?

Dr. Patmas: I might be an expert at this. There are two common problems. One is failure to manage up with relationships with your superiors and that can be difficult for physicians who enter into the executive world. We understand a lot about health care and the clinical side of things. Sometimes we might be perceived as a threat and if we don't manage that relationship very effectively, it can cause you to get derailed. Another thing is failure to appreciate the very deep differences in the cultural realm between medicine and management. This leads to ineffective communication. There's nothing worse than seeing a VPMA, CMO or physician leader come into a meeting with non-physician executives and revert to a communication pattern they might have had in the OR or they might have used at morning report or rounds. Management people communicate differently. As physicians, we may not appreciate the subtle differences in that communication style, and that can be a source of derailment. Becoming an executive is a real challenge for physicians. It requires a lot of nurturing and mentoring.

Dr. Patmas:
Management people communicate differently. As physicians, we may not appreciate the subtle differences in that communication style, and that can be a source of derailment.

Dr. Lundstrom: I would agree with everything that you said, and I think we all make mistakes. How you recover from them is almost as important as recognizing you made one. Some of those leadership skills you referenced that you don't learn in the classroom in medical school are so important to being an effective leader. Developing relationships is important as well. It's really all about: "Let's sit down over the balance sheet; let's sit down over coffee and have a discussion." You get to know people personally which really is helpful.

Dr. Patmas: One of the biggest challenges is accepting a consensus opinion that you don't agree with. But if that's the direction that the organization is going to go, then you leave that meeting room and support that. The good of the many outweighs the needs of the few. Sometimes, you just have to realize the organization is going in that direction and, as part of the leadership, you have to support that. A surgical friend of mine mentioned that when you knock over that OR instrument tray and walk out of the room, there is someone to help clean it up in the operating room. As a manager, there's not. Those are the things you kind of have to learn to temper and get your point across in different ways.

Mr. Esselman: We have about 10 minutes and would welcome questions that any of you have for our panelists on corollary topics or anything that's on your mind.

Lundstrom:
We all make mistakes. How you recover from them is almost as important as recognizing you made one.

Audience and Panel Engagement

Do specialties in medicine determine whether or not you're more likely to be successful or not?

It happens to be that I know a lot of intensivists that have ended up going into management. Some of that comes from our bedside negotiations with the various specialists that come in to care for children and I think my career as a pediatric intensivist prepared me very well to move into management. Again, that's one person's experience.

If you look at physician executives, you'll see where all the internists have gone.

How do you transition from a CMO at a health plan to a CMO in a hospital system or a health care system?

I think the most important transition is you'll no longer need a personal security detail when you leave the health plan.

In many ways the skill sets are the same, understanding finances, quality, etc. Hospital operations may be the one area where you may need to beef up, so you might not be able to make an immediate transition from CMO in a health plan to CMO in a hospital. You may have to take either a CMO position in a smaller organization or a different physician leadership position to prove that you have the operational skills for the inpatient environment.

Could you give your thoughts about physicians going into the management role and finding themselves totally overwhelmed with issues in time management?

It's very similar to managing your time as a busy clinician. One of the things that is so important is to have that executive team because you've got a lot of people around that can help. I think it's part of the skill set that you were describing in terms of that collaborative teamwork motto. As a doctor I need to recognize that I don't have to take everything on myself and that I have a whole team. We're all working together and pulling together to achieve the goal. Under these circumstances, I need to reach out to the team when there are issues to discuss or when things aren't going quite as well as they could to get some help in the executive leadership team.

It's a challenge to learn that delegation is not you "wimping out" or avoiding it. The other key thing is an excellent administrative assistant that manages your calendar for you. My administrative assistant is truly my partner and knows when I've been pushed too long. She'll change things around a bit, but it takes a while to get that type of person.

Dr. Boyd:
As a doctor I need to recognize that I don't have to take everything on myself and that I have a whole team. We're all working together and pulling together to achieve the goal.

I would also suggest finding a personal mentor or coach. You might meet them through networking with ACPE. This could be someone you have a relationship with that can help you or someone you can call up and bounce questions off of. That's a really useful thing to have and within ACPE we have that coaching mentoring function.
I've been available, I've relied on others for assistance at times and I think we can help each other. I would encourage you to do that. Identify some folks you can call up and say: "I'm running into this kind of an issue. How would you handle it?"

When you start out, you often want to know everything so that you feel that you're in control of it and at some point, you have to let go. Delegate so that you make someone responsible for making sure you know what you need to know.

I'm concerned about the so-called "Caducean ceiling" in regards to the movement up to the CEO or higher positions than CMO. Is it important to those of us at the CMO level whether this is a terminal position, whether we're just going to get more operational duties over time.

At Cejka Search we are seeing a greater likelihood for organizations to consider physicians for the top jobs. Ten years ago, when we started an engagement, we would ask: "Would you consider a physician?" They would consider a physician, but unsaid was that they didn't think a physician has what it takes to do the CEO's job. Five years ago, the answer was, "We'd like to see some physicians in the mix," and more physicians started to raise their hand. Now when we have CEO recruitments, our clients almost all say, "We want to see a couple of physicians in that final slate of candidates." They are seriously considering those physicians. We're also seeing physicians raise their hand for more operational roles, chief operating officer roles, so it is spreading beyond CMO, to COO and CMIO. I'm seeing medical leaders move into the CIO role which is not all tech, but it is a larger leadership role. Physician leaders are branching out.

Besides the fact that they're branching out into different roles, there are new opportunities. A lot of accountable care organizations or accountable care organization look-a-likes are really looking for that physician leader as a CEO to drive integration, because that's going to be so important to the success of the ACOs bundled payment, etc.

The Caducean ceiling does exist. It's diminishing over time, but I would also caution that the pursuit of the CEO role for its own sake is maybe not the goal. We can have tremendous influence and really impact health care and serve our organizations very powerfully in non-CEO roles. I remind you that for most of his life at Apple, Steve Jobs was not the CEO. The role of senior vice president or chief medical officer can be very, very important, and it's not all just about being CEO.

Is there anything in the survey addressing the issue of longevity in a position? It seems that the stability a physician would have had in their practice or in a more conventional position, non-executive role, is not going to be present in the leadership role. Does it look like the length of time in a position is shortening?

Longevity is five years on average for all physician executives. From 2007 to 2009 and then 2009 to 2011, it wasn't significantly different in each title category.

The one thing I would add to that though: Historically, when we would see a C-suite change in a health care organization or a hospital, the change would include CEO, CFO, and most generally the COO. The CMO was left alone. That's not been the case over the last three to five years. When there's a sweeping change, because of the influence of the physician practices and the medical groups, there's more demand on the CMO role to be integrated into the C-suite team than there ever has been.

Having the board support is not a guarantee either, so it really depends. Sometimes you come in as the change agent. When you come in as the change agent and make all the changes you need to make in the organization at the end of your tenure, you lose effectiveness so you really have to move on. It depends on what the position is and what you're brought in for as well.

Well, we're at the end of our time. Thank you to our panelists and our audience.

About the Panelists

John L. Boyd, III, MD, MBA, CPE, FAAP
Chief Executive Officer and Chief Medical Officer, Scott & White Children's Hospitals and Clinics

Dr. Boyd is the Chief Executive Officer and Chief Medical Officer for Scott & White Children's Hospitals and Clinics. Scott & White created the position and appointed Dr. Boyd to oversee eight clinics and two hospitals. Dr. Boyd has built his career on entrepreneurial group practice pursuits and progressively greater leadership roles in hospitals and academic settings, including medical faculty appointments at SUNY, Harvard, Duke, University of Arizona, Creighton, and Texas A & M. Most recently, he was the Chief Medical Officer at St. Joseph's Hospital and Medical Center.

Ben H. Brouhard, MD
Senior Vice President, Senior Search Consultant, Cejka Executive Search
Former Executive Director, Women's and Children's Service Line Associate Chief Medical Officer for Education, MetroHealth Medical Center

During his 15-year tenure, Dr. Brouhard has been among MetroHealth's top physician leaders with oversight for operational, clinical and academic areas, including as Chair of the Department of Pediatrics and Executive Vice President of Medical Affairs. He previously served nearly ten years with the Cleveland Clinic and the University of Texas Medical Branch, respectively. Dr. Brouhard has developed a passion for the development of physician leaders through active participation and direction of search committees. In 2012, he transitioned into the search consulting profession, joining Cejka Executive Search.

Tammy S. Lundstrom, MD, JD, FACP and FSHEA
Former Chief Medical Officer, Providence and Providence Park Hospitals
Associate Professor of Medicine and Adjunct Professor of Law, Wayne State University

Dr. Lundstrom is nationally recognized for leadership and education in quality initiatives and public policy. She has been recently appointed to the CDC's Healthcare Infection Control Practices Advisory Committee. She is also Past Chair of the Public Policy Committee for the Society of Healthcare Epidemiology of America, and is a faculty member for the CDC/SHEA training course in Healthcare Epidemiology. Throughout her career, Dr. Lundstrom has contributed her expertise and commitment to public health, quality and patient safety through service to organizations such as JCAHO, the National Quality Forum, the Agency for Healthcare Research and Quality and the American Society for Healthcare Risk Management.

Michael A. Patmas, MS, MD, CPE, FACP, FACPE, FACHE
Chief Medical Officer, Woodland Healthcare

Dr. Michael Patmas is the Chief Medical Officer for Woodland Healthcare. He's responsible for the integration of all clinical processes and staff at Woodland Healthcare, a system comprised of Woodland Memorial Hospital and Woodland Clinic Medical Group, all a component of Catholic Healthcare West. Progressing through his career and roles of increasing leadership responsibility, Dr. Patmas' management experience spans diverse environments ranging from his current role in leadership of an integrated delivery system to health plans, academic medicine, and group practice in which he served most recently as a chief executive officer.

About Mr. Esselman

Paul Esselman
Executive Vice President and Managing Principal, Cejka Executive Search

Mr. Esselman has nearly 20 years of health care experience and possesses an exceptional understanding of the industry. He has worked with executive leadership in hospitals and health systems, academic institutions, physician group practices, and managed care. Mr. Esselman merges his extensive management and health care expertise to effectively identify and evaluate the skills and competencies of a health care executive, resulting in successful search assignments.