

LEVERAGING AMC CLINICAL LEADERSHIP TO ACHIEVE PERFORMANCE EXCELLENCE

THE SITUATION

Academic medical centers (AMCs) are complex entities with many component organizations, each of which have distinct missions and goals. Clinical departments, in particular, have multiple missions – clinical practice, teaching, and research – and department Chairs often function more as leaders of independent entities than interrelated components of a broader academic and clinical enterprise. Getting clinical department leadership “on the same page” and establishing accountability for achieving multiple goals is essential to creating a high-performing academic medical center. Failure to view department Chairs as leaders with similar accountabilities as non-physician leadership is a fatal flaw in the organization design of many of today’s academic medical centers.

BACKGROUND

Because of their multiple missions and academic tradition, AMC clinical departments have historically operated with a large measure of autonomy. Within a broad framework established by the medical school, department Chairs typically have significant flexibility in pursuing their own research, teaching, and clinical agendas, and the traditional triad of the academic clinician as a “triple threat” virtually always orders the value of the three divisions in that order. Furthermore, performance improvement and accountability are frequently uncomfortable concepts in the academic world, where the tenure system protects senior academicians’ ability to pursue their work insulated from internal or external pressures. Chairs are frequently selected based on their academic and research acumen – important skills that are essential to recruitment of junior faculty, who in turn are mentored and promoted based largely on their academic productivity. Unfortunately, such an emphasis often neglects the business skills needed in the modern clinical enterprise. In today’s resource-constrained operating environment, expectations of department Chairs as clinical leaders must go far beyond their traditional academic role.

Department Chairs today play what can be argued is the most critical managerial role in the performance of the clinical enterprise. They set objectives and priorities within their departments, control the allocation of clinical resources, influence service levels and referral relationships, and drive clinical performance. They recruit, retain, and reward or punish their staffs in a variety of ways. As a result, the performance of clinical department Chairs is a major determinant of the success or failure of the clinical enterprise. To an AMC, clinical department Chairs play a role analogous to division vice presidents or senior business unit executives in an industrial or service corporation.

Achieving alignment and accountability of key managers with organizational goals is a fundamental precept of organization design in high-performing businesses. Achieving performance improvement in the AMC requires that departmental leadership be aligned with clinical system goals and objectives, and accountable for results. Establishing alignment and accountability with clinical department Chairs can significantly improve the ability of academic medical centers to achieve and sustain meaningful performance improvement. This requires several steps:

- Setting clear expectations for performance
- Monitoring performance against expectations
- Conducting periodic (usually annual) performance reviews
- Tying compensation to performance

Each of these steps is discussed below.

SETTING CLEAR EXPECTATIONS

Clear expectations are the cornerstone of alignment and accountability. Clear expectations establish a shared understanding between the Chair and his or her supervisor(s) about the scope of clinical leadership responsibilities and the results to be achieved. While employment agreements can be helpful in defining expectations, they are typically and appropriately more focused on issues surrounding the employment relationship. Because the employment contract is unlikely to change, more adaptable methods of clarifying expectations are the position description and specific performance objectives.

- **Position Description** – An effective position description establishes a mutual understanding of the expectations of the role including scope of responsibilities (e.g., credentialing and monitoring of clinical activity of both employed faculty and private physicians), priorities (e.g., prudent departmental fiscal management), and management behaviors (e.g., provides supervised physicians with timely performance reviews; works effectively with other department Chairs and AMC management). Position descriptions should be reviewed and revised periodically to ensure that the mutual understanding between Chair and supervising executive remains current.
- **Annual Objectives** – Annual objectives define specific, time-bound, and measurable results that, if accomplished, have a material impact on the success of the organization. Objectives should be driven by and aligned with the clinical system's strategic plan. They often incorporate intermediate (e.g., quarterly) milestones. Annual objectives typically have two components:
 - **Team Objectives** – Shared objectives across a team or group of managers to which the individual contributes but does not have a controlling impact on the team's ability to meet the objectives. Team objectives for department Chairs would typically be the same high-level objectives held by the rest of the clinical enterprise's senior management team and would include such measures as overall operating margin, clinical quality, and patient satisfaction.
 - **Individual Objectives** – Results for which the manager will be held individually accountable. For the department Chair, these might include department financial performance, patient access measures, departmental clinical quality measures, and/or the successful launch of a new clinical program. They should also include the Chair's responsibilities in organization-wide leadership roles and collegial work with other clinical departments.

To be meaningful, annual objectives must be tied to the institution's reporting system, providing regular feedback regarding progress.

One element often left unclear in establishing expectations for department Chairs is the Chair's accountability for the performance of the hospital services under their "command," including the financial performance of community physicians ("voluntary faculty") who may contribute significantly to the clinical enterprise. While some AMCs operate with closed medical staffs, many are dependent on the work of community physicians for both clinical activity and teaching. When department Chairs double as chiefs of service, they have an implicit dual responsibility for the health of both faculty practice plan and community practice. Making such responsibilities explicit can help the Chair more effectively deal with natural competition between private community physicians and employed faculty.

A final note regarding clear expectations acknowledges what are often complicated reporting relationships for many department Chairs. In many AMCs, Chairs will report jointly to the medical

school dean and hospital CEO. In some cases, these reporting relationships involve not just separate functions within a single organization, but two legally independent entities. Improving the alignment and accountability of department Chairs with institutional mission and strategy **requires** that deans and the hospital CEO be “on the same page” with respect to Chair performance expectations and priorities.

MONITORING PERFORMANCE

Once performance expectations are clearly established, the next step is ongoing monitoring of performance against expectations. There are two key components to effective monitoring – management information reporting, and periodic departmental performance review.

- **Management Information Reporting** – Availability of information is rarely an issue in AMCs. What is often problematic is the availability of timely, clearly reported information focused on the right performance variables. Several problems are common:
 - Inter-organizational transfers between medical schools, faculty practice plans, and hospitals
 - Inability to accurately differentiate costs and revenues associated with research, teaching, and clinical service
 - Intentional shifting of profits / losses between organization units for external reporting purposes
 - Mixed use of cash basis and accrual basis accounting
 - Shifting cost allocation methodologies that result in artificial apparent changes in performanceReporting that is inaccurate, unclear, or focused on the wrong variables is often dismissed by leaders as irrelevant. Department Chairs, like any business unit executives in the organization, need clear, easily understood feedback on performance relative to their objectives in order to make the ongoing adjustments necessary to improve performance.
- **Periodic Departmental Performance Reviews** – These meetings, typically held monthly or bi-monthly, bring together the Chair, other senior departmental leadership, and senior clinical enterprise leadership for a focused review of the department’s progress in meeting performance objectives, obstacles to performance improvement, and plans for overcoming those obstacles.

REVIEWING PERFORMANCE

Although ongoing, informal performance feedback associated with performance monitoring is a well-accepted principle of effective management, it is not a substitute for formal, institutionalized review and feedback. For department Chairs, as with other senior operating executives, an effective performance review process should have three components:

- **Annual Individual Performance Review** – Many academic organizations have a tradition of five year departmental reviews. For today’s clinical enterprise, a five-year review cycle is inadequate. Annual performance reviews should include a formal assessment of the Chair’s performance relative to his or her position description and annual objectives. It should be delivered personally by the Chair’s supervisor (in the case of dual reporting relationships – e.g., medical school dean and clinical system CEO – the review should be developed and delivered jointly by both supervisors). Importantly, it should incorporate formal feedback from representative department members, peer department Chairs, and clinical system counterparts

(e.g., hospital COO or clinical service line executive). Similarly, the Chair should perform a yearly in-person review for each of his or her direct reports within the department.

- **Development Planning** – An important component of the annual review, singled out here as a separate part of the process because of its importance, is the development plan. Few annual reviews do not identify opportunities for growth and improvement. The development plan is a formal agreement between supervisor and Chair regarding concrete steps to be taken by both the organization and the Chair to improve performance and/or prepare for additional responsibilities.
- **Leadership Review** – High performing organizations inside and outside healthcare are adopting an important process that we'll call the "leadership review." A leadership review is a periodic (usually annual), top-down review of an organization's leadership. Senior leaders / executives present to a small team of top management a summary of the performance of leaders / managers in their segment of the organization. Leaders are ranked based on their performance. High performing leaders are targeted for promotion and development opportunities; low performing leaders are evaluated for rehabilitation potential or separation. The disciplined, focused conversation ensures that top executives are knowledgeable about the organization's leadership, holds senior managers accountable for development of mid- and lower-level management, and reinforces a consistent ethic of upgrading the organization's leadership.

TYING PAY TO PERFORMANCE

Linking pay to performance is a key element of any effective performance management process. Whether by adjustments to base pay through incentive compensation, the organization must have a way to hold leaders accountable for performance. With the widespread popularity of incentive compensation programs over the past half decade, there are few organizations that have not adopted some form of incentive pay. The mere presence of an incentive compensation plan, however, does not guarantee an effective link between pay and performance. Common mistakes include:

- Allowing Chairs to define their own incentive pay as part of a department incentive compensation plan
- Basing incentive pay on complex formulas with multiple objectives, diluting the impact of key performance dimensions
- Basing incentive pay solely on departmental performance, neglecting to include team or enterprise objectives
- Basing incentive pay on objectives totally out of the control or influence of the individual leader
- Basing incentive pay on the wrong objectives (e.g., billed vs. collected revenue)
- Making incentive pay too small a percentage of total compensation to ensure attention on performance objectives

Effective incentive compensation should have three components:

- **Organization Performance** – based on the overall performance of the organization as a whole and tied to the same objectives held by top management
- **Team Performance** – based on the performance of the Chair's department / clinical service
- **Individual Performance** – based on performance against individual objectives

To avoid diffusing focus over a broad range of performance factors, an effective incentive plan should be based on a limited number of key objectives (no more than 4-6). Care should be taken to ensure that achieving target objectives has the desired result on overall enterprise performance. Objectives should be both objective and measurable, and accurate feedback regarding performance relative to objective should be available throughout the year.

CONCLUSIONS

High-performing organizations don't just happen. They are the result of careful design and consistent application of proven organization development concepts that, at their core, are intended to ensure alignment with the organization's mission and objectives, and accountability for results. The same concepts that work effectively in service and industrial organizations can work effectively in the academic / clinical enterprise. Department Chairs play critical senior leadership roles in today's clinical enterprise. Setting clear expectations, conducting regular performance reviews, effectively linking pay to performance, and periodically evaluating leadership on an organization-wide basis can help ensure the Chairs' alignment and accountability.

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BDC Advisors, LLC would be pleased to assist you and your organization in improving performance management within your academic and clinical leadership. If you would like further information, please contact William T. Eggbeer, Director with BDC Advisors, LLC at (415) 247-1000.