ARTICLE

PHYSICIAN LEADERSHIP

5 Common Physician Leadership Council Mistakes for Employed Physician Networks

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Though they have varied names – "Physician Leadership Councils," "Physician Advisory Councils," "Physician Governance Councils," etc. – engaging a core group of physician and advanced practice provider (APP) leaders in the problem-solving and decision-making process is critical to the success of an employed physician network.

While many employed networks have built some form of Physician Leadership Council (PLC), the design, implementation, and functional execution of these Councils vary widely from organization to organization. For some health systems, the PLC evolved to become foundational to successfully progressing the network from a collection of independent practices into a true multispecialty group exhibiting a common culture and uniform clinical and operational processes. This result represents the ideal PLC functional state. For other health systems, the PLC was designed to accomplish this but if it becomes stagnated, it becomes a painful exercise in which

providers are brought into a room once a month to be shown data, the context of which they do not fully understand, and be asked to provide input on decisions that administration has already made and begun acting upon. Finally, some PLC's evolved into or were conceived to solely be a communication vehicle and and are viewed by network members as mouthpieces for system administration.

Designing and attaining ideal PLC function is vital to the network's evolution through the **HSG Physician Network Growth Phases**. The network cannot develop a Strategic Focus until physician leadership becomes ingrained in the organization and augments the way the network is managed. For networks struggling with their PLCs, HSG has observed a number of common errors that ultimately lead to the Council not being as effective it could be– or, even worse, being totally ineffective and slowly being abandoned due to perceived lack of value.

MISTAKE #1: The PLC Charter is not aligned with the PLC's desired function.

The Charter is critical to defining the form and function of the PLC. Among other things, it sets expectations for its membership and defines the spectrum of and limitations to the PLC's decision-making authority. Strong PLCs embrace a well-written charter that is specific in its description of the PLC and is currently relevant to the PLC's operation. For struggling PLCs, the Charter is often a document that was developed many years ago perhaps by a different leadership group, has not been reviewed or embraced by its present membership, and does not sync with the goals of the PLC in its current function. Ensuring the Charter is current, explicit, inclusive, and understood by its membership is essential to a well-functioning Council.

MISTAKE #2: Having the wrong composition of providers and administration.

Having the right composition of provider members on the PLC is crucial for its function. On one hand, the Physician Leadership Council membership should be relatively inclusive to achieve the broadest input during Council deliberations and effect the greatest acceptance for Council decisions. On the other hand, the membership must be small enough to be able to effectively make decisions. Additionally, the membership should be representative of the network's specialty mix, geographic locations, ages and experience levels, gender, and APP mix.

MISTAKE #3: The PLC is not incorporated into the Employed Network Organizational Chart.

The PLC must exist as a well-understood and explicitly listed entity on the employed network's organizational chart. Strong PLCs have a clear purpose on the organizational chart, ensuring that non-PLC providers and other staff/ stakeholders understand that the group is valuable to decision-making and initiative execution. Struggling PLCs tend to not be delineated on the network's organizational chart and operate with an unclear purpose.

MISTAKE #4: Engaging providers in leadership functions without having a shared vision of what they are leading toward.

A Shared Vision of what the employed network wants to be in 5-10 years is critical to building a path that the PLC utilizes to guide the organization. The Shared Vision and its associated prioritized potential strategies provide a co-owned, fully embraced framework upon which to set the network's course. Executing the Shared Vision should be fundamental

to the PLC's work and should drive the activities and decision-making processes within the Council and the network. Without this type of strategy in place, the PLC – and network – administrative agenda becomes largely reactive and is not focused on driving the organization directionally forward in its evolution.

MISTAKE #5: Lack of PLC committees to drive the PLC agenda.

Without a robust committee structure, the Physician Leadership Council cannot fulfill its ideal purpose, as there is not an effective mechanism to efficiently accomplish the actual work of the Council. Without an effective committee structure, the PLC agenda remains driven by Administration and perpetuates the impression that the PLC is merely expected to adopt and communicate the Administration's agenda. An effective committee structure involves more network providers in network function, permits the detailed work of the PLC to be efficiently undertaken, and incorporates a multidisciplinary approach to network operations. Typically, this structure is populated with committees such as Operations, Finance, Quality, Clinical Informatics, and perhaps Customer Service/Patient Experience when not incorporated under the Quality Committee. Many organizations also create an APP Committee to provide a professional exchange forum for these important network members under the PLC umbrella. Each of these committees should have at least one PLC member to promote continuity, but otherwise should consist of a diverse constituency, including other employed providers, employed network leadership and management individuals, and various network and hospital program representatives pertinent to committee function. These committees execute the "work" of the PLC and essentially drive the PLC agenda. The PLC committee structure does not obviate the need for strong involvement of the network's leadership and management infrastructure, which is crucial for successful PLC, PLC committee, and overall network function and success.

Organizations who are struggling with these mistakes – and desire to rectify them – are typically most successful if they pursue a hard restart of the PLC in the context of reconfiguring the network organizational structure and/or developing a network Shared Vision with potential strategies to refocus the PLC. When a PLC has been ineffective for too long, anything short of dramatic change will struggle to overcome the inertia of futility that has been created by the mistakes made in the prior development and operation of the PLC.

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