Physician Management and Leadership Education at the Cleveland Clinic Foundation: Program Impact and Experience Over 14 Years

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As the challenges of leading in healthcare become more complex, healthcare institutions have increasingly emphasized the importance of leadership training for physicians. Several institutions have offered in-house training programs. This paper describes the 14-year experience and evolution of physician leadership development training at the Cleveland Clinic. We describe the curriculum, organization, and goals of the Leading in Health Care course, which is offered to high-potential physician leaders. As a metric of the success of this physician leadership effort, we report the number and types of business plans developed in the course that have been either implemented at the Cleveland Clinic or have directly affected plans for program implementation.

Key words: Physician leadership development; course; organizational development; professional education.

As the challenges of leading in healthcare become more complex, healthcare organizations are increasingly providing customized, in-house programs on management education and leadership development for their physicians and administrators. As evidence of this growing activity, Scott et al. reported the results of a 1995 survey to 122 chief executive officers of highly rated hospitals and health maintenance organizations in which 31 percent of respondents reported offering such organized institutional leadership programs. The reported costs of offering such programs were high even in 1994, ranging from $25,000 to $250,000 at that time.

In the context that in-house management and leadership education courses are widespread and expensive, program evaluation and assessment of return on institutional investment are important considerations. Indeed, 70 percent of the responding institutions in the aforementioned survey felt that leadership programs were “effective in achieving their stated objectives.” However, little attention has been given to specific metrics of program success or to evaluating the institutional impact of offering such programs. To address this gap, we undertook the current report with two goals in mind:

1. To describe the 14-year evolution and current content of the Cleveland Clinic Foundation’s (CCF’s) Leading in Health Care course (which has included attendees’ developing business plans for innovative ideas); and

2. To better assess the specific benefits of this long-standing program by cataloging the business plan proposals that have been generated by course attendees and describing the frequency with which such ideas have been implemented at the CCF.
METHODS

To assess the types of business plans proposed and the frequency with which business plans proposed by course attendees have been implemented, we compiled and reviewed a list of business plan projects developed by course attendees since the inception of our in-house course in 1990; each business plan proposal was then reviewed with regard to whether it had been implemented at the CCF and its impact if so.

RESULTS

Description and Evolution of the Course

Before 1990, the CCF had encouraged high-potential CCF staff physicians to attend outside physician leadership and business courses. While course attendees valued the experience, several shortcomings were recognized: (1) the course material did not address issues and opportunities specific to the CCF; (2) physicians attended courses separately, so that opportunities for building teams for the benefit of the CCF were not realized; and (3) the significant expense of tuition, travel, and time away was not deemed to be offset by institutional return.

To address these shortcomings, a course regarding practice management and leadership development was first developed and offered within the CCF in 1990; and, except for a one-year hiatus in 2002 (when the course was radically restructured), has been offered annually since.

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The course has evolved over time to meet the institution’s and attendees’ needs, with three chronologic phases of offerings as follows:
1. The initial approach of encouraging faculty to attend outside courses, 1985 to 1989;
2. Offering the Executive Program in Practice Management, 1990 to 2001; and
3. Offering the Leading in Health Care course, 2003 to present.

The courses offered in each of these three phases are described below.

The Initial Approach (of Sending “High-Potential” Physicians to Outside Courses)

The initial approach to offering management and leadership development was to encourage selected high-leadership-potential physicians to attend courses offered by outside organizations, such as the American College of Physician Executives’ Physicians in Management Seminar and the Chief of Service course offered at the Harvard School of Public Health. For five CCF physicians deemed to have high potential and motivation, the Cleveland Clinic leadership approved subsidizing their tuition to undertake masters in business administration training. As a measure of the success of this approach, all five remain at the CCF more than 20 years later: one is the chief executive officer of Cleveland Clinic Florida and former chief of staff in Cleveland; another is the current chief of staff and former chairman of the division of surgery; a third is the former chairman of the department of dermatology and current director of the office of practice management; and the other two currently hold other important clinical and administrative roles at the CCF.

The Executive Program in Practice Management

In 1989, appointment of a new CEO and the desire to offer training that conferred business and leadership skills to a larger number of physicians and administrators with a focus on the specific context of the CCF prompted development of an in-house course, called the Executive Program in Practice Management, that was offered to nominated CCF physicians and administrators. As described in an earlier paper, this program was first offered in 1990 with the initial class composed of department and division chairs and their respective administrators. With an expected goal to foster collaboration between emerging physician leaders and administrators, the course was offered thereafter to a mixed group composed of physicians and nonphysician administrators.

As shown in Table 1, the course consisted of a series of 24 sessions that were offered on alternating Friday afternoons and Saturday mornings at an off-site location. The curriculum (Table 1) covered a comprehensive, broad range of health-related management topics and included a longitudinal learning project in which small teams of physicians and administrators were expected to develop a formalized business plan for an idea to improve the CCF that was generated by each group. The last session of the course was dedicated to the teams presenting their business plans to the entire group, with discussion about learning and the feasibility of the proposals following each.

The Leading in Health Care Course

The sudden death of one of the key faculty members in late 2001 caused the 2002 course to be canceled and reorganized for 2003. Based on focus groups in which leadership development needs of the CCF Staff and feedback from prior course attendees were solicited, and on deliberations by the course co-directors (PLB and JKS), the revamped course, called Leading in Health Care, was first offered in 2003. Specifically, new topics regarding leadership and organizational development were introduced (e.g., emotional intelligence, situational leadership, conflict resolution and negotiation). Most of the more traditional business and practice management aspects of the curriculum (e.g., business plan development, healthcare finance, the regulatory environment of medicine) were preserved.
Based on the desire to increase the number of physicians receiving this leadership training, the restructured Leading in Health Care course was offered to physicians only; emerging physician-leader nominees were sought from department and division chairs, and, in 2003, a cohort of 32 physicians was selected by the office of professional staff affairs based on diversity of specialty, practice venue, gender, race, and age. As shown in Table 1, the course consisted of a series of eight sessions offered roughly once monthly on Fridays at an off-site retreat center of the CCF called The Foundation House. As a measure of institutional commitment and value attached to the course, the time away from practices at the course was accounted as “Clinic business” versus as “vacation” or “meeting time,” the latter two of which represented finite pools of time from which attendees would have had to draw in preference to other activities in these categories.

**Table 1. Typical Schedules of the Course in its Three Phases**

1. Initial Approach of Sending High-Potential Candidates to Outside Courses
   - Curriculum dictated by offering organization
2. Executive Program in Practice Management (1990–2002)
   - Accounting
     - CCF balance sheets and operating statements
     - Budgeting process
     - Capital budgeting
   - Healthcare finance
     - Financial concepts/terminology
     - Valuation
     - Risk analysis
     - Investment
     - Reimbursement/payors
   - Marketing
     - SWOT analysis
     - Competitive advantage
     - Market research/segmentation
     - Product line development
     - Consumerism
   - Management information systems
     - Databases
     - Spreadsheets
     - Integrative technologies
     - Strategic modeling
     - Information as competitive advantage
   - Human resource management
     - Hiring/laying
     - Performance evaluation
     - Legal issues
     - Compensation
     - Motivation and development
   - Organizational development/behavior
     - Institutional identity and culture
     - Negotiation/conflict resolution
     - Teambuilding
3. Leading in Health Care course (2003 to present)
   - CCF-specific information
     - History of the CCF
     - The CCF Vision
   - Business topics
     - Marketing in healthcare
     - Healthcare finance
     - Writing a business plan
   - Leadership development topics
     - Emotional intelligence (with 360-degree feedback and executive coaching)
     - Situational leadership
     - Negotiation and conflict resolution
     - “Crucial conversations” model
     - Human resource management
   - Other
     - Medicolegal issues

Table 2 summarizes a comparison of features of the three phases that have been discussed. The course evolved with the vision that ideal features of a course offering would include:
- High throughput (i.e., being able to offer the program to as many high-potential physician leaders as possible);
- Development of a multidisciplinary group of colleagues that learns to work together and develop synergies to advantage the institution;

**Topics included medicolegal and regulatory issues in healthcare, business topics, and topics regarding personal and organizational development.**

Topics presented in the Leading in Health Care course (Table 1) regarded information specific to the CCF, medicolegal and regulatory issues in healthcare, business topics, and topics regarding personal and organizational development. Though not included in the first offering of the Leading in Health Care course in 2003, a business plan activity (i.e., in which groups of four to six course attendees were assembled to identify a proposed innovation and to develop a business plan to explore its feasibility and implementation) was re-introduced in the 2004 and subsequent offerings of the course. Further modifications to the course in its third offering in 2005 included increasing the number of attendees to the maximum capacity of 36 (based on the maximum capacity of the off-site room to accommodate a group seated around a U-shaped table) and offering an opening weekend retreat that emphasized team-building activities and business-plan and team selection. Another innovation for the 2005 offering was to invite nonphysician administrators to serve as business plan “mentors,” with the idea that their collaboration with physician business plan teams would simulate and enhance the interaction between physician leaders and administrators at the CCF in developing business initiatives. As in the Executive Program in Practice Management, the final session of the course was devoted to the business plan groups’ presenting their business plans to the entire class for discussion.

**Comparison of the Three Phases**

Table 2 summarizes a comparison of features of the three phases that have been discussed. The course evolved with the vision that ideal features of a course offering would include:
- High throughput (i.e., being able to offer the program to as many high-potential physician leaders as possible);
- Development of a multidisciplinary group of colleagues that learns to work together and develop synergies to advantage the institution;
• Offering a curriculum spread over time (i.e., offering the course as spaced sessions over a prolonged period of time to allow pre-work before consecutive sessions and time for attendees to “ingest” the course learning and to form mature, working groups);
• Manageable institutional cost for offering the course;
• Institution-specific training (i.e., experience over time has suggested that offering information and context specific to the CCF has had special value);
• Formation of project-dedicated teams within the course (e.g., around developing business plans) to provide a forum for practicing the teamwork and leadership lessons presented in the curriculum; and
• Encouragement of innovative ideas to address institutional challenges.

Table 2 rates the three phase offerings using a 1- to 3-star ordinal rating scheme, where three stars indicates a high degree of demonstrating the rating feature and no stars (indicated as 0) indicates a low degree of satisfying the rating feature. Based on this rating scheme, relative advantages and disadvantages of the three phases can be discussed. For example, the initial approach of sending faculty to outside courses had the advantages of ease of offering and maximal networking opportunities with colleagues from other institutions; as noted earlier, these advantages were somewhat offset by high institutional expense and resultant limited throughput, low opportunity to network with colleagues within the institution, and little attention to institution-specific information.

Advantages of the Executive Program in Practice Management included high physician-administrator interaction, lessened institutional cost outlay, moderate physician throughput (because the invited groups consisted of half physicians and half nonphysician administrators), a customized curriculum (based on features of the CCF), and encouragement of institution-specific innovation (through encouraging and developing business plans for projects to enhance the institution).

Finally, advantages of the Leading in Health Care course include having the highest physician throughput, having acceptable institutional outlay, and featuring a customized curriculum that was offered in sessions separated over time. Also, the course created an environment that encouraged networking among a diverse group of physicians, which was otherwise difficult in a large, spread-out organization. These favorable features were slightly offset by lower intra-institutional networking capability than the Executive Program in Practice Management (because all attendees are physicians rather than mixed administrators and physicians) and lower extra-institutional networking opportunities compared with the first phase strategy of encouraging attendance of outside courses.

A Review of Business Plans Submitted During the Course Offerings

Review of the business plans developed during the 13 offerings of the Executive Program in Practice Management and the Leading in Health Care Course shows that a total of 49 business plans were submitted. These business plans were categorized as follows:
• Proposal of a new service or program (24 percent, n = 12);
• Proposal of a multidisciplinary clinic or service (10 percent, n = 5);
• Proposal of a new facility (8 percent, n = 4);
• Service line expansion (24 percent, n = 12);
• Marketing program (14 percent, n = 7); and
• Process enhancement (18 percent, n = 9).

Of the 49 plans submitted, 30 (61 percent) have either been implemented or have directly affected program implementation at the CCF. Examples of business plans that have been adopted as new services or programs at
the CCF include: a “short stay” unit as an extension of the emergency room; a geographic and service expansion of the sports medicine program to secondary school athletic programs and to athletically active individuals; a multidisciplinary Inflammatory Bowel Disease Center; a dedicated Women’s Health Program; and a national/international telemedicine consultation program.

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Process-improvement initiatives that arose from the business plan activity include: adoption of a system-wide electronic medical record; coordination and integration of post-acute care services into one administrative entity; a Web-based program for patients to access their personal health information and to schedule appointments; and a redesign of ambulatory surgical services at the main campus and regional locations of the Cleveland Clinic.

An important outcome of the process of preparing formal business plans was identifying projects that either should not be implemented (because the ideas appear impractical on being vetted to a larger group) or that require major modification to be actionable. Examples of proposals that were deemed impractical at the time were establishment of a new nursing school on the main campus of the Cleveland Clinic and providing a patient transport van service to bring patients from outlying areas to our institution.

Occasionally, business plans that were developed in the course addressed ideas that, unbeknownst to the proposers, were currently being considered by other institutional decision-makers. In these instances, the development of the business plans sometimes influenced the institution’s plans, either by causing the Clinic’s plan to be modified or even abandoned. An example of a business plan that caused the institution’s plan to be modified was a proposal to offer on-site childcare for employees. Analysis of the business plan in the course led to a conclusion that the costs of developing a childcare program staffed by Cleveland Clinic employees made the proposal unattractive. Instead, based on the appeal of the service but at a more favorable cost structure, the institution elected to proceed by contracting with a national childcare service to offer the service on campus.

**DISCUSSION**

In presenting the development, 14-year evolution, and curricula of the CCF’s Leading in Health Care course for physicians, the current report adds to the published experience of leadership development courses for physicians.3-5,7 Also, in cataloging the business plans that were developed by groups of course attendees as their course projects, this report extends available experience by describing this novel aspect of the course and by suggesting that the business plans that have been implemented or abandoned represent an important institutional return on the investment of developing and conducting the course.

Despite the significant investment in conducting the course, which consists of the faculty costs and, most prominently, the opportunity costs of occupying 30 to 40 physicians for 9 to 10 working days a year, the Leading in Health Care course at the CCF has been staunchly supported by leadership based on the impression that training future leaders and cultivating impactful ideas through the business plan activity has value for the organization. Indeed, belief in the success of the Leading in Health Care course has prompted the institution to extend management and leadership development training to a larger proportion of the Clinic faculty by developing a “Clinic University,” in which a curriculum of courses will be offered to all members of the faculty wishing to partake. Furthermore, embedded within the concept of this Clinic University is a “culture of expectation,” in which members of the faculty who envision assuming leadership positions within the institution will be encouraged to take such courses, both as evidence of leadership competence and as demonstration of their commitment to self-development to assume leadership roles.

In the Leading in Health Care course, the activity of having groups work together over the nine-month course to develop business plans that are presented to the entire group as a final course activity is a distinctive and important aspect of the course, which has conferred important benefits for the course and for the institution. Regarding benefits to the course, the activity of developing a proposal and writing a business plan provided an ongoing real-world context in which to apply the didactic concepts presented in the classroom. Second, the business plan projects bound the small working groups together as equals to frame and solve a relevant problem in which the group was interested. Third, the activity allowed participants to directly impact and change the organization in a manner different from what they could normally do. Taken together, to our knowledge, these features of the business plan activity distinguish this program from other available physician-oriented management programs.

The activity of developing business plans has also conferred benefits to the CCF and has enhanced organizational effectiveness. First, the business plan activity has already created a rich inventory of well-developed and critically evaluated ideas for institutional innovation and growth. Second, training a growing community of physicians to develop business plans that use standard and mandatory metrics for evaluating associated costs and outcomes has contributed to a culture in which ideas are
advanced in a rigorous and standardized way, allowing better assessment and ranking of ideas by institutional leaders to justify human and capital investment. Finally, in encouraging a standardized, rigorous approach to proposing and developing ideas, the business plan activity has helped to minimize the political dimension of decision-making about which ideas to endorse and implement. Taken together, these benefits, along with the actual institutional value of those business plan ideas that have been implemented over the 14-year history of the course, have earned the institutional impression that the course has a favorable return on investment and have encouraged expanding course availability to a larger proportion of the Clinic physicians.

Still, we are aware of opportunities to extend the analysis of the return on the institutional investment in conducting this course. For example, in the book *Calculating Human Resource Costs and Benefits: Cutting Costs and Improving Productivity,* Spencer has described an approach to assessing the return on investment of activities like the Learning in Health Care course. By way of broad overview, Spencer’s strategy calls for calculating the costs associated with offering the course (e.g., expenditures for the few outside faculty participants, facility costs, and opportunity costs associated with physicians’ being away from their practices for the course) and comparing these costs to the savings accrued to implementing successful business plans. As an example, in assessing the savings associated with implementing the business plan of creating a Web-based program by which patients could access their records and schedule appointments, one would assess the value of the incremental volume of resulting patient visits to offset the cost of implementing the program and compare this value to the aggregated expense of offering the course. To the extent that this and all implemented business plans accrue value over time that exceeds the cumulative cost of offering the course, the expenditure for the course is justified in a return on investment context. We are currently planning such an analysis, which we expect will be the subject of a separate report.

Overall, we believe that our favorable experience in developing and offering an in-house physician leadership development program recommends this approach to other health care institutions wishing to foster the development of its physician leaders.

**REFERENCES**

AQ 1: For these prices, do you need to state if they are per year, per course, or some other unit of measure?

AQ 2: In table one, please spell out “SWOT” in the footnotes.

AQ 3: Do you have the city/state for Wiley for this book?