

A study produced in partnership  
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The California Endowment,  
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# Taking the Pulse

The State of Medical Director  
Leadership in California  
Community Clinics



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Please note that the conclusions and recommendations in this report are those of the authors and may or may not reflect the views of individual members of the Community Clinic Leadership and Workforce Study Advisory Committee.

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# Taking the Pulse:

## The State of Medical Director Leadership in California Community Clinics

### Introduction

**C**ommunity clinics and health centers face significant challenges in recruiting and retaining the leaders they need.<sup>1</sup> Compared to other for-profit and nonprofit health care organizations, community clinic leaders also bear responsibilities for providing broader ranges of health care services, addressing more complicated patient needs and working with more numerous funding mechanisms.

The community clinics field is especially challenged to find and keep medical directors; these physicians play key leadership roles in overseeing clinical staff and functions, working with a clinic's Chief Executive Officer (CEO) and other senior leaders and balancing a range of clinical and administrative responsibilities.<sup>2</sup> Few physicians acquire experience during their careers that adequately prepares them for such a position.

The national physician shortage, particularly physicians who specialize in primary care and family medicine, compounds clinics' recruitment difficulties. Cultivating and developing the next generation of clinic medical directors is further hampered by competition for experienced physicians from other health care areas (e.g., HMOs and other health plans), clinics' geographic requirements (e.g., recruitment to rural areas) and clinics' need for greater alignment between patient and provider diversity.

Despite these challenges, there are also unique opportunities for those who work for and with clinics to pursue at this time. Clinic staff as a whole are highly motivated by their organizations' missions, which presents an attractive opportunity to recruit others who are inspired by community health care and teamwork. In addition, the quality and cost effectiveness of care provided by community clinics has only been improving over time. This large system of health care, which serves more than four million people annually, is well positioned for health care reform. These can be compelling arguments for medical professionals and health care leaders who want to play an active role in improving health care.

1 In this report, we use the term "clinic" to include both clinics and health centers, acknowledging that most organizations refer to themselves as clinics but some prefer to be called health centers.

2 Many clinics and clinic consortia use the position title of executive director to designate their chief executive officer. In this report, when we use the term chief executive officer (CEO) we also include within it those leaders who hold the title of executive director.

## Related Studies of Community Clinic Leaders

**I**n 2003, two important studies by CompassPoint Nonprofit Services (CompassPoint) examined the leadership needs of the community clinics field and offered specific action steps. The reports from the studies provided valuable information on the experience, perspective and future plans of two key groups of clinic leaders: *Bridging Medicine and Management* focused on medical directors and *Securing the Safety Net* focused on CEOs. These reports helped community clinics, nonprofit health care organizations and other health care stakeholders better understand the environment in which community clinics were dealing with leadership turnover and development.

Approximately five years later, two leading health care funders in California—the Blue Shield of California Foundation (BSCF) and the Community Clinics Initiative (CCI), a joint project of Tides and The California Endowment—decided to take another look at leadership in the community clinics field and assess the degree to which the situation changed over the past five years. The two funders engaged a team of consultants from BTW *informing change* (BTW) and CompassPoint to conduct this assessment of the field, with the goal of providing a snapshot of the current leadership landscape and implications to stimulate discussion and action among clinic leaders, their partners, funders and other community clinics stakeholders.

## This Report

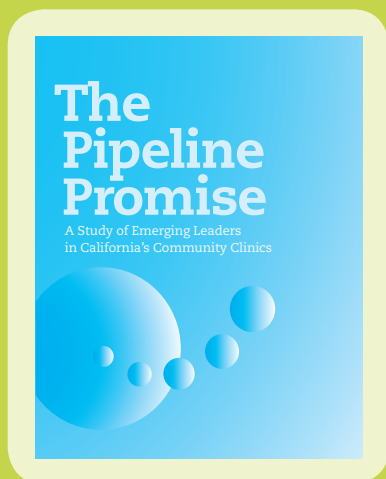
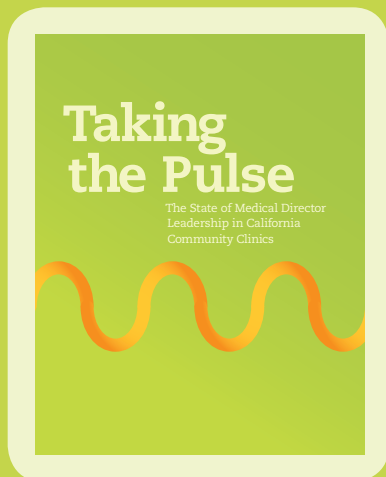
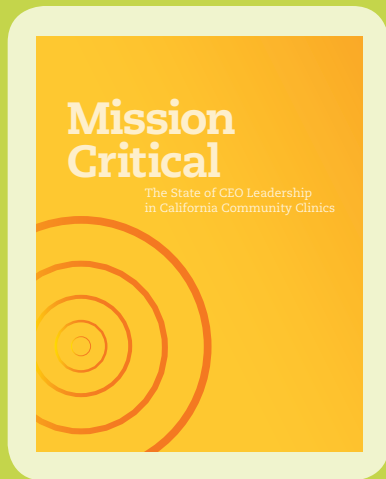
**T**his report is part of a set of three companion reports that together describe the findings of the 2009 Community Clinic Leadership and Workforce Studies. While the three studies are related, each one takes an in-depth look at a distinct group of staff within community clinics and clinic consortia.<sup>3</sup> The studies and their subject groups are:

- 1 This report, *Taking the Pulse: The State of Medical Director Leadership in California Community Clinics*, which focuses on current medical directors who hold the most senior clinical position within these settings;
- 2 *Mission Critical: The State of CEO Leadership in California Community Clinics*, which focuses on current CEOs of clinics; and
- 3 *The Pipeline Promise: A Study of Emerging Leaders in California's Community Clinics*, which looks at other staff who may become the future CEOs or medical directors or hold other senior positions in community clinics.

A brief fourth publication, titled *Community Clinic Leadership in California: The State of the Field and Implications for the Future*, highlights key findings from all three studies and considers cross study implications. This brief and the three studies can be accessed from [www.btw.informingchange.com](http://www.btw.informingchange.com).

This set of studies comes at an important time for the community clinics field. The results of these studies provide timely information about the best ways to work with clinics and clinic consortia to make informed decisions as to how best to support and retain current leaders as well as identify and prepare future ones.

<sup>3</sup> A variety of names are used to describe regional and statewide clinic membership groups, including consortium, association, council and network. In this report, we use the term consortium.



An advisory board representing different aspects of the community clinics field advised and guided this assessment and the development of the reports.

## Community Clinic Leadership and Workforce Studies Advisory Board

Yasser Amman, President and Chief Executive Officer, University Muslim Medical Association

Carl Coan, Chief Executive Officer, Eisner Pediatric and Family Medical Center

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## Methodology

**T**his report focuses specifically on the medical directors of community clinics and clinic consortia. Similar to the 2003 study, we focus on medical directors' perspectives on their current positions, career paths and aspirations, job challenges and rewards and professional and leadership development needs (e.g., training and support).

In November 2008, BTW and CompassPoint sent an e-mail to 155 medical directors of California community clinics and clinic consortia describing the study and containing the link to the web-based survey. In addition to sending several reminder e-mails, advisory board members encouraged participation through direct communication with non-respondents. The survey remained in the field for approximately four months and was completed by 71 medical directors—68 from clinics and three from clinic consortia—for a 45% response rate. BTW also conducted one 45-minute focus group with nine medical directors as well as separate telephone interviews approximately 20 minutes in length with five medical directors who were unable to participate in the focus group.

When analyzing survey data, we explored differences across a variety of demographic (e.g., gender, age) and organizational (e.g., clinic location, clinic size) factors.<sup>4</sup> As part of our analysis, we also compared current survey data to findings from the 2003 study of medical directors as well as the current study of community clinic CEOs; we include relevant information where it is available and instructive.

In addition to the information obtained in the survey, focus group and interviews, we drew from informal conversations with a variety of stakeholders in the field as well as from more formal conversations in which the authors participated during the study period. These discussions and conversations took place at health care-focused venues, including BSCF's Clinic Leadership Institute training sessions and working group meeting and the California Primary Care Association's (CPCA) 2009 Statewide Community Health Center Workforce Strategy Meeting.<sup>5</sup>

- 4 When looking at differences in responses based on clinic size, we defined small clinics as those having fewer than 50 full-time employees. We also looked at survey responses by primary clinic location (urban, suburban, rural, frontier and other), since organizations tend to experience certain challenges due to their geographic location. The medical director survey did not include questions about respondents' organizations; as a result, organization-specific data were collected during the analysis period from both the CEO survey data and additional follow-up research.
- 5 When reviewing the data presented in this report it is important to note that they are not without limitations. The data are self-reported by those who completed a survey and/or participated in a focus group or interview; as a result readers should take caution in generalizing these findings broadly.

# Findings

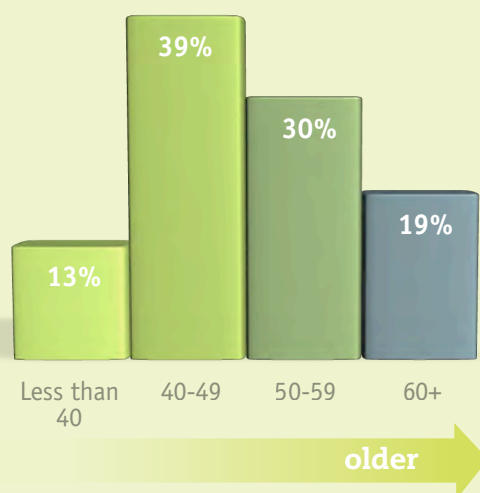
**I**n this section of the report, we describe the profile of medical directors who participated in this study and the characteristics of the organizations they represent. First, we discuss these individuals' career pathways and key motivating factors that led them to take their positions as medical directors. Next, we look at their current work experience including their satisfaction in this position, the most significant rewards and challenges of their leadership position, the extent to which they share leadership with others and important sources of support and training. Finally, we look towards the future of medical directors, including the extent to which current medical directors plan to stay in their positions and what is taking place to cultivate and diversify the next generation of medical directors.

## Profile of Medical Director Respondents

- ▶ More than half of respondents are male (53%) and identify as White/Anglo (59%).
- ▶ The average age is 49 (range: 34 to 66); slightly more than half (53%) of respondents are less than 50 years old with about one-fifth (19%) age 60 or older.
- ▶ While nearly all medical directors (91%) indicate completion of a residency, some also completed a doctorate (39%), master's degree (25%) and/or fellowship (17%). The most common residency specialties and Board certification disciplines include family medicine, internal medicine, obstetrics/gynecology and pediatrics. The most common additional degrees that respondents have completed are Master of Public Health and Master of Business Administration.
- ▶ Compared to current CEOs of community clinics and clinic consortia who responded to a similar survey this year, medical directors are younger (53% vs. 23% who are less than 50 years old) and are less likely to be female (47% vs. 60%) or White/Anglo (59% vs. 67%).

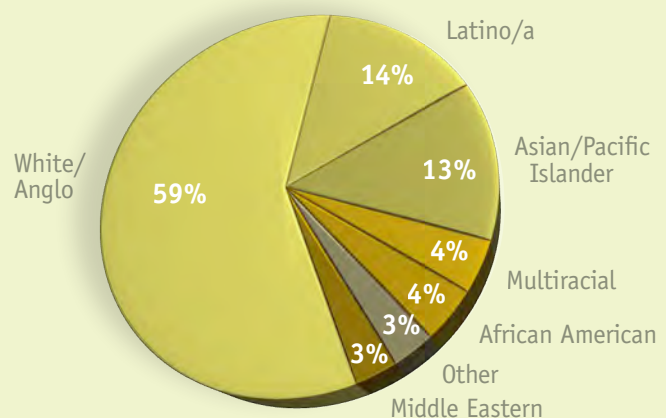
Average age of medical directors

(n=70)



Race/ethnicity of medical directors

(n=71)

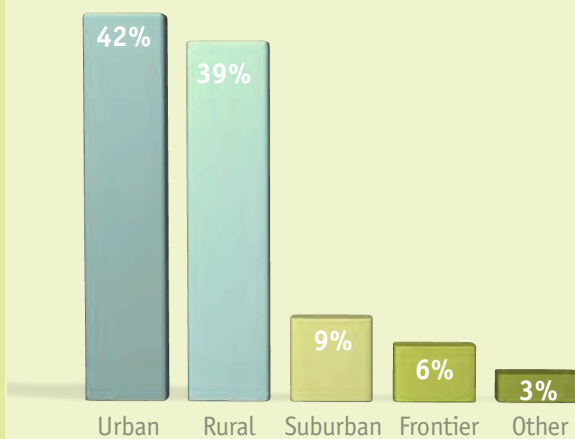


## Profile of Organizations Where Medical Directors Lead

- ▶ Eighty-one percent of the medical directors in this study work in a community clinic and the remainder hold the medical director role for a consortium of clinics.
- ▶ Almost half (42%) of respondents work at community clinics and clinic consortia that are located in primarily urban areas; the majority (83%) of organizations have less than 10 clinic sites.
- ▶ More than half (56%) of organizations employ 100 or fewer full-time employees and have annual operating budgets of less than \$10M (52%).
- ▶ Most organizations (71%) serve fewer than 30,000 unduplicated patients annually.
- ▶ Nearly all (98%) of the organizations were founded prior to 2000, with the highest concentration of organizations (46%) established in the 1970s.
- ▶ Compared to the organizations represented in this year's CEO study, medical directors' organizations are slightly larger in terms of budget, number of full-time staff, and number of patients served.
- ▶ Compared to the 2003 study of medical directors, annual operating budgets are slightly larger now than they were in 2003 (52% of 2008 respondents and 67% of 2003 respondents reported budgets of less than \$10M).

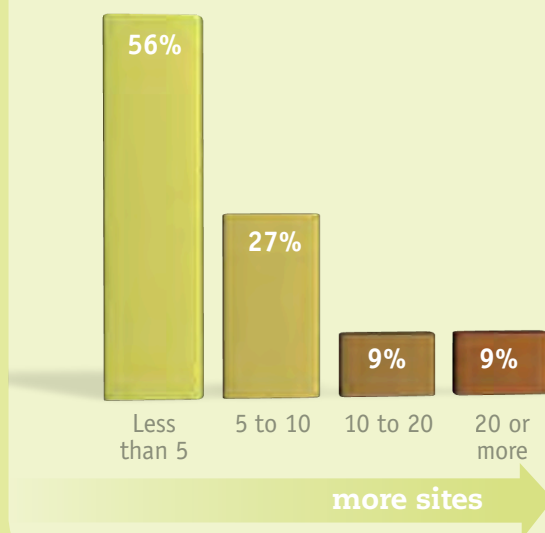
### Organization's primary location<sup>6</sup>

(n=66)



### Number of sites within current organization

(n=68)

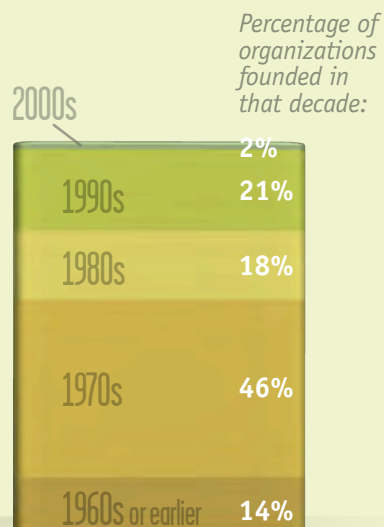


<sup>6</sup> "Frontier" represents areas that are sparsely populated rural areas isolated from population centers and services. Source: [http://www.raconline.org/info\\_guides/frontier/frontierfaq.php#definition](http://www.raconline.org/info_guides/frontier/frontierfaq.php#definition). "Other" includes organizations that did not fit into one of the stated categories (e.g., "small town") as well as organizations that do not view one of their multiple clinic sites as a primary clinic location.



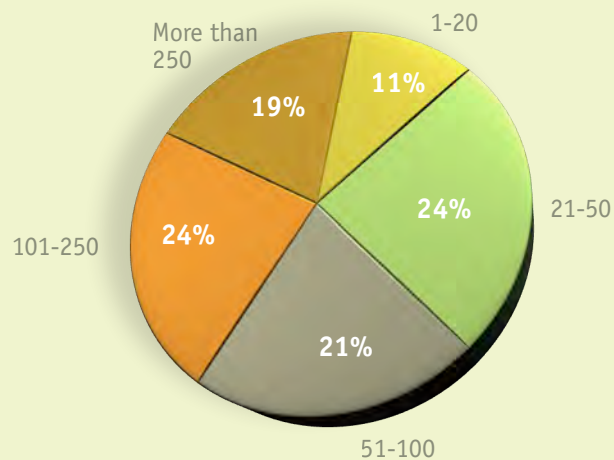
### Year organization was founded

(n=63)



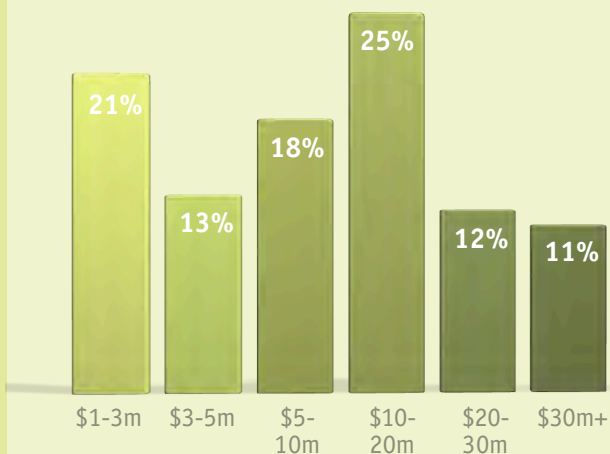
### Number of full-time equivalents employed by organization

(n=62)



### Organization's annual operating budget

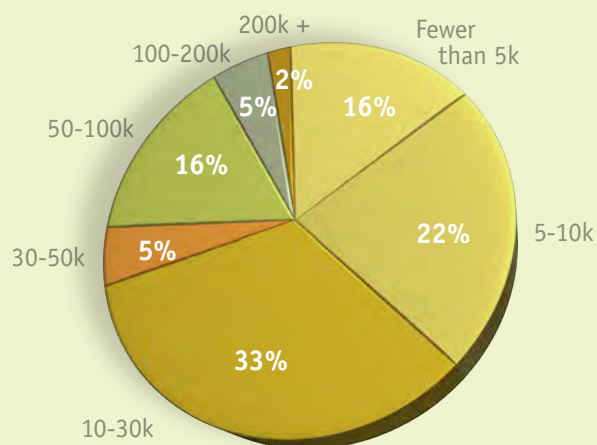
(n=56)



larger budget →

### Number of unduplicated patients served at organization each year

(n=58)



# Path to Becoming a Medical Director

## Key Findings

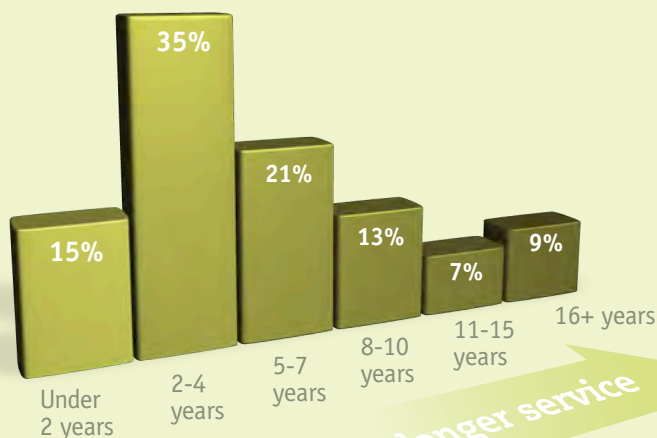
- ▶ Similar to CEOs of community clinics and clinic consortia, a significant majority of medical directors have been in their position for a relatively short period of time.
- ▶ The majority (76%) of medical directors worked in the community clinics field, either at their own clinic or in another clinic setting, prior to their current position.
- ▶ Medical directors' motivations for taking their position parallel those of community clinic and clinic consortia CEOs and have remained constant over time.
- ▶ Many respondents did not plan or prepare to become medical directors; rather they responded to an unanticipated opportunity, request and/or need.

## Experience at Organization and in Community Clinics Field

On average, medical directors have held their current position for about six years with a range of tenure from one to thirty-two years. One half (50%) of respondents have been in their position for a relatively short period of time—four years or less. Compared to the 2003 study, current medical directors have held their position for a slightly longer period of time; nearly two-thirds (64%) of respondents to the earlier study held their position for four years or less. Medical directors' tenure in their current position is also similar to that of CEO study participants with about half of CEOs also having been in their position for four years or less.

### Years in current position

(n=71)



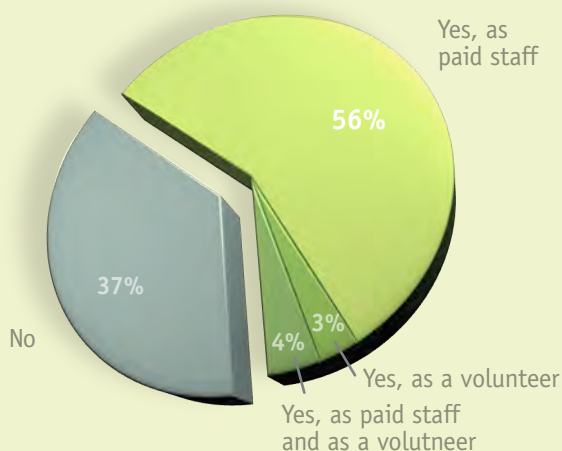
Nearly half (45%) of all medical directors have been in the community clinics field for ten years or less. Those who have held their current position for a shorter amount of time also tend to be newer to the community clinics field.

A similar percentage of medical directors in the two studies noted that their current position is their first time serving as a medical director (70% in 2008 vs. 66% in 2003). Nearly two-thirds (63%) of medical directors worked and/or volunteered at their current clinic prior to assuming their current role. Of those recruited to the medical director position from within their organization, about three quarters (73%) were staff physicians immediately prior to becoming medical director. While this is the same overall percentage as in the 2003 study, the type of positions from which medical directors were recruited within their organization has shifted; medical directors are recruited less frequently from volunteer physician positions (9% to 4%) and more frequently from staff physician (63% to 73%) and associate medical director (and other similar) positions (19% to 22%).

**Nearly two-thirds of medical directors worked and/or volunteered at their current clinic prior to assuming their current role.**

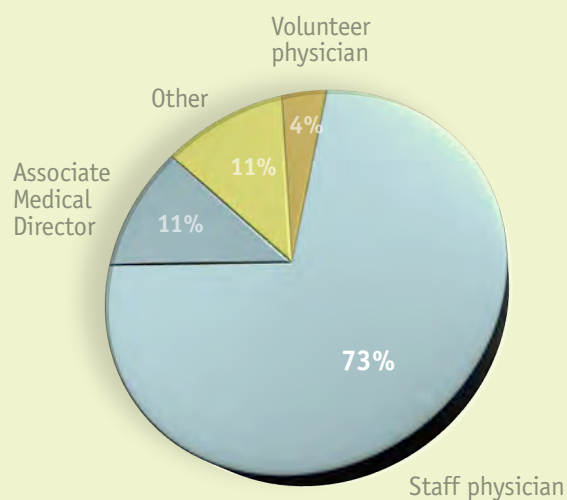
#### Worked at organization before becoming medical director

(n=71)



#### Internal position prior to becoming medical director<sup>7</sup>

(n=45)

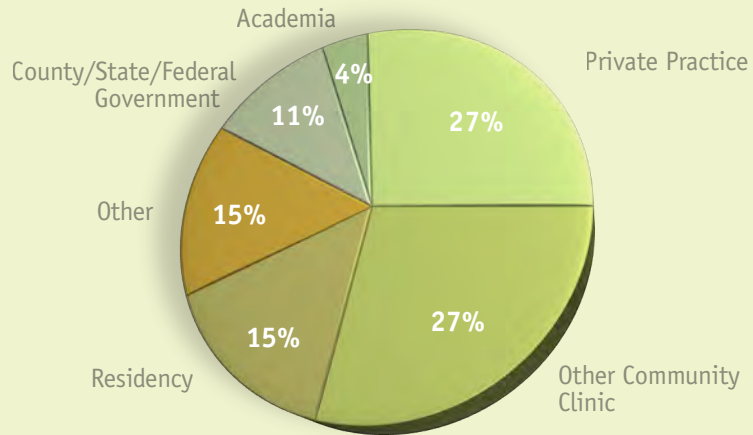


Of those medical directors who came from other organizations or sectors prior to taking their current position, about one quarter came from another community clinic (27%) and one quarter from a private practice setting (27%). Compared to externally hired medical directors in the 2003 study, an organization is now more than twice as likely to recruit from another community clinic (27% in 2008 as compared to 11% in 2003) and less likely to recruit from residency (22% to 15%) or HMOs or other health plans (8% to zero).

<sup>7</sup> Other positions include interim medical director, locums provider, medical director for HIV and homeless patients and part-time medical director.

### External type of organization or sector prior to becoming medical director

(n=26)



## Motivation for Becoming the Medical Director

“The mission has kept me doing what I do.... Working really hard doesn’t matter because I am doing something I think is important.”

Respondents’ primary motivation for taking the medical director position was the desire to make a difference in the community (mean rating: 5.24) and support of the organization’s mission (mean rating: 5.2); medical directors report being least motivated by salary (mean rating: 2.73) and benefits (mean rating: 2.3).<sup>8</sup> Medical directors and CEOs appear to have been motivated by very similar factors in deciding to take their current positions. Medical directors’ mean ratings for each motivational factor as well as the overall rankings of these factors are similar to the 2003 study.

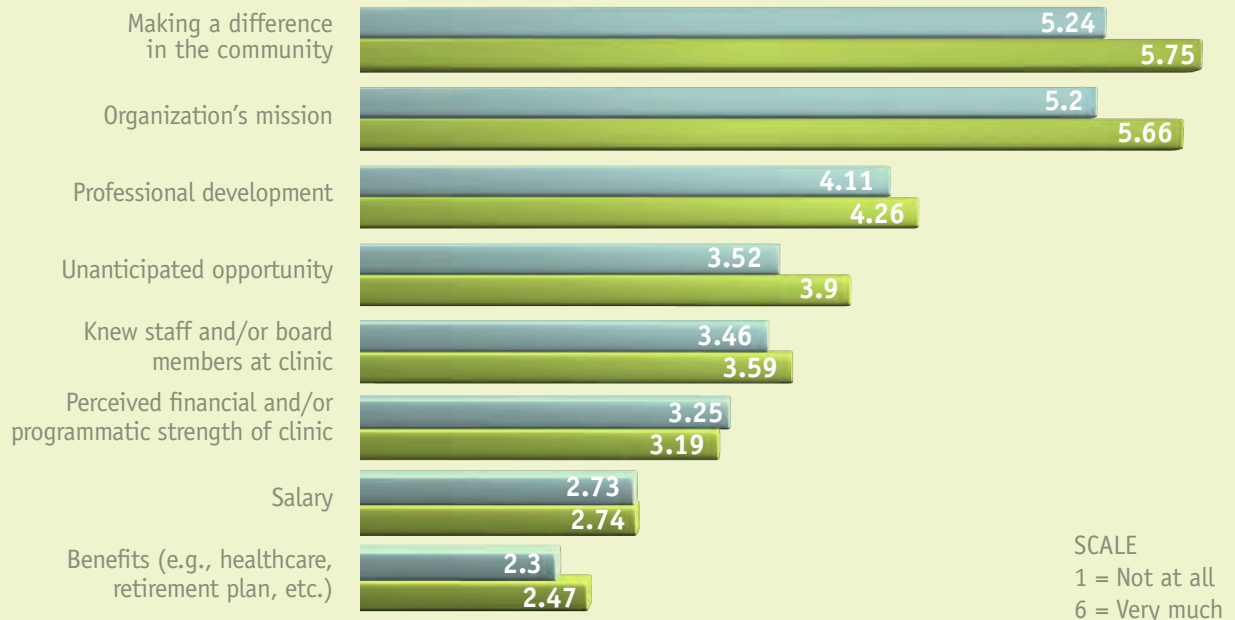
When asked about the extent to which different aspects of the organization’s mission attracted them to and retain them at their current job, medical directors chose taking care of the underserved (mean rating: 5.59) as the most important, followed by the health care delivery aspect (mean rating: 5.17). They are least attracted to the policy/advocacy aspect of the mission (mean rating: 4.59), which is an area in which physicians don’t typically receive training.

Medical directors who have received such training and been involved in policy/advocacy talk about its rewards—how such efforts provide the opportunity to have a bigger impact on the community and contribute to their professional development and job satisfaction.

<sup>8</sup> All mean ratings reported throughout this document are based on a 6-point scale. Though the specific values differ slightly depending on the survey question, “1” represents strong disagreement or dissatisfaction and “6” represents strong agreement or satisfaction.

## Motivation of medical directors and CEOs to take current position

(n=71)



greater motivation

Medical Directors (n=71)  
CEOs (n=121)

## Most attractive aspects of organizational mission

(n=71)



more attractive

SCALE  
1 = Not at all  
6 = Very much

# Experience in Current Medical Director Position

## Key Findings

- ▶ Most medical directors work full-time, splitting their time fairly evenly between administrative and clinical duties; tensions exist for those with insufficient time to complete administrative responsibilities.
- ▶ Medical directors note similar challenges as clinic CEOs in regard to managing staff and staff recruitment and retention.
- ▶ Some of the areas of work which medical directors find most rewarding and satisfying—community and policy work—are areas in which medical directors note the lowest levels of involvement.
- ▶ Finances and fundraising rank lowest among areas in which medical directors share responsibility with others in their organization, despite the fact that these are the areas of most significant challenge for community clinic and clinic consortia CEOs.
- ▶ Almost one-third of medical directors do not have a clinic management team; these medical directors typically serve in a small clinic.
- ▶ Meeting regularly and working effectively with clinic management teams improves medical directors' overall work satisfaction.

## Hours Worked and Administrative vs. Clinic Time

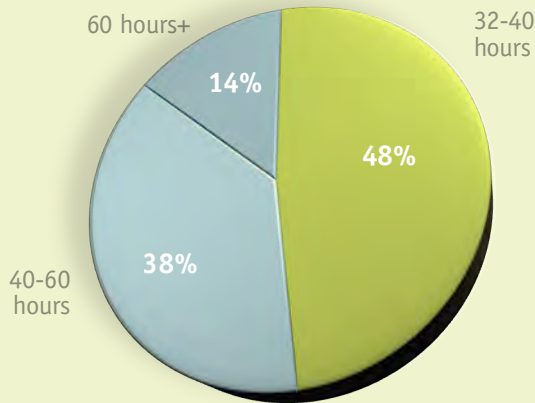
Most medical directors (86%) work full-time, between 32 and 70 hours per week with a mean of 46 hours; a small percentage of medical directors (11%) work 60 hours per week or more. These findings are very similar to the 2003 study. The part-time medical directors (14%) work between 10 and 32 hours per week, with a mean of 26 hours. Those medical directors who work the longest hours report the lowest levels of job satisfaction.

On average, medical directors spend a little less than half their time on direct patient care (48%), with the rest of their time spent on administrative tasks (52%). Many medical directors talk about the tensions between administrative and clinic time, especially those noting particularly small amounts of administrative time. As one medical director notes, “We are caught between administrative responsibilities on one side and the rest of our responsibilities on the other. It’s a great challenge and opportunity to coordinate and integrate everything into the overall mission and also to deliver that day-to-day in the clinic.”

“It’s a great challenge and opportunity...”

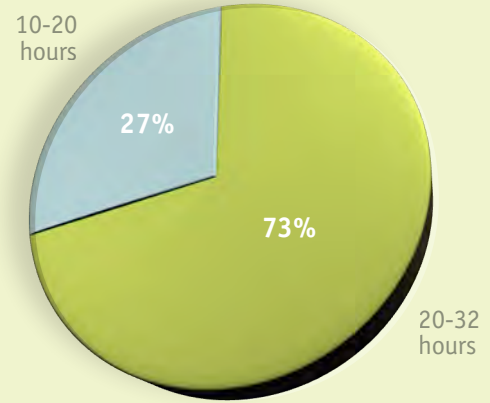
### Hours worked among full-time employees

(n=56)



### Hours worked among part-time employees

(n=15)



## Fulfilling and Challenging Aspects of the Medical Director Position

Medical directors find many aspects of their position fulfilling; the most fulfilling factors are working with and making a difference in their community (mean ratings: 5 and 5.35, respectively). Some of the most fulfilling factors for being a medical director, however, also have a correlated challenge. For example, medical directors appreciate working in communities that need their help but are challenged by dealing with limited resources to meet patient needs (mean rating: 4.56). One medical director describes this dilemma: “The most satisfying [thing] is helping people of all socioeconomic backgrounds. We serve patients who are insured and uninsured.... We also have equal quality of care, so if you have Medi-Cal you get the same care.... [However] all those things that are positive can also be negative. You never know if there is insurance and if you have someone who isn’t covered you need to figure out how to help them get what they need.”

### Most fulfilling factors of being a medical director

(n=71)



more fulfilling



“I’m working with some of the younger physicians to help them in their work. I’m willing to hold their hand for the first few times. That’s an important part of the job but one that is off the ledger completely.”

“The most satisfying [thing] is helping people of all socioeconomic backgrounds. We serve patients who are insured and uninsured.... We also have equal quality of care, so if you have Medi-Cal you get the same care.... [However] all those things that are positive can also be negative.

The top two challenges identified by medical directors focus on staffing, both managing staff (mean rating: 4.8) and recruiting and retaining staff (mean rating: 4.63). In addition to ensuring clinical positions are filled with qualified staff, medical directors must find the time and resources to develop and retain the staff they have. Medical directors’ comments illustrate their sense of responsibility to ensure their staff’s job satisfaction, making sure that they receive appropriate training, job responsibilities and workloads. Reflecting on this issue, one medical director states: “you need to keep your staff from revolting, keep them productive and somewhat happy and protect them from being abused and from overly high expectations.”

Among the lowest rated challenges of being the medical director are those related to working with other individuals, including coordination with other providers in the community, the clinic patients, the CEO and board of directors (mean rating range: 2.52 to 3.41). The low ranking of these challenges is similar to what is reported by CEOs.



## Most challenging factors of being a medical director

(n=71)



more challenging

## Least challenging factors of being a medical director

(n=71)



less challenging

## Sharing Leadership with CEOs and Other Organizational Colleagues

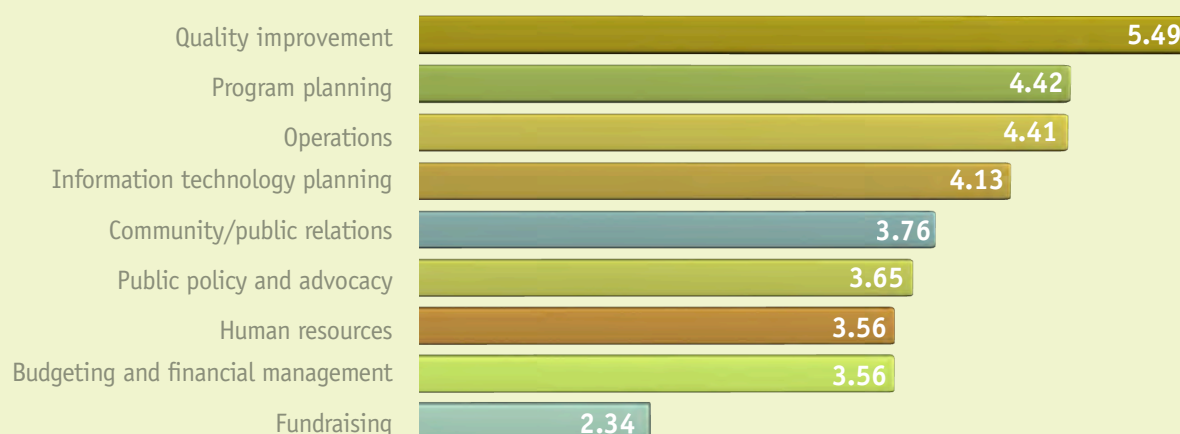
Most medical directors (92%) are members of their CEO's management team and share a wide range of organizational responsibilities with their CEO and other senior leaders. Quality improvement is the area of greatest responsibility (mean rating: 5.49) followed by other more internally-focused responsibilities such as program and information technology planning and operations (mean ratings range: 4.13 to 4.42). Some of the least shared areas of responsibilities are those that are more externally focused: community and public relations as well as public policy and advocacy (3.76 and 3.65, respectively). Human resources, which tends to be more directly connected to staff recruitment and retention, and a significant challenge for both medical directors and CEOs, is another area where medical directors share less responsibility. The same is true with areas related to organizational finances such as budgeting, financial management and fundraising (mean ratings: 3.56 and 2.34, respectively); these areas are rated as significant challenges by community clinic and clinic consortia CEOs.

Medical directors who are most satisfied with their position tend to work more closely with their CEO and others on the senior team. The most satisfied medical directors express a sense of empowerment as clinic leaders, rather than a sense of being a rubber stamp or carrying out others' ideas and vision. One medical director reflects on his positive experience: "I am supported by an open, positive relationship with administrative staff, both the CEO and the whole senior management team. There is synchronicity with common goals, vision and open communication with the group."

Medical directors reflect on the challenges of being part of a senior management team, especially when they first undertake their position. For most, they have never participated in this type of leadership team and must learn to integrate this role with the pull of clinical demands. "Learning how to be a useful part of that administrative team is important," says a medical director. "This is a struggle for myself, to corral the clinical side of my work."

### Shared responsibility for management functions

(n=71)



more shared

“As a leader you’re part of a team, you aren’t isolated at the top. To be effective, you have to have buy-in from people you work with; it’s best to have a bottom-up instead of top-down approach.”

In terms of the staff structure that medical directors oversee, almost two-thirds (61%) have a clinic management team which they lead. Those who do not have clinical management teams tend to work in smaller organizations. Most medical directors meet with their teams on a regular basis, with nearly half (44%) meeting weekly, an increase from 35% of clinic management teams meeting weekly in 2003. Other teams meet less frequently with their clinic management teams: monthly (31%), twice a month (21%), every other month (2%) and quarterly (2%).

A little more than half (55%) of medical directors report that they have a second in command who can oversee clinical responsibilities and make decisions, to different extents, in their absence; this is an increase from the 2003 study in which 45% reported having such a person. The most common titles of medical directors’ second in command include associate, assistant or site medical director, clinic manager or administrator, director of clinical service or another clinician.

Overall, respondents think that they work effectively with their clinic management teams (mean rating: 4.80). Compared to the overall group, those who report working more effectively with their clinic management teams feel more effective in their medical director position (mean rating: 5.13 vs. 4.61) and more satisfied with their job (mean rating: 5.00 vs. 4.69). Some reflect on the benefits of sharing leadership within these teams and their specific model in doing so. For example, in one clinic, the medical director oversees three medical co-directors who each take responsibility for one aspect of the clinical work. This arrangement allows the medical director to maintain a satisfying amount of clinical work while providing a variety of leadership development opportunities for other physicians.

## Important Sources of Support

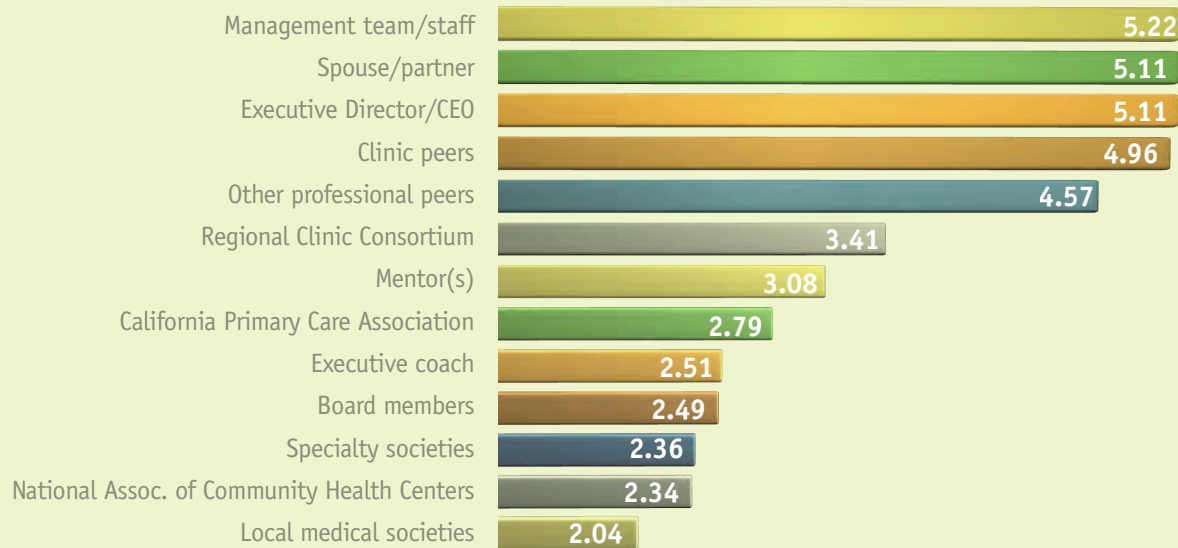
Medical directors are more likely to consider informal sources of support as most important. These sources include peers within their organizations such as their management team (mean rating: 5.22) and CEO (mean rating: 5.11) as well as clinic peers (4.96) and other professional peers (4.57) which may be within or external to their organization. CEOs seem to be especially strong sources of support for medical directors when they shared common values, experiences and expectations; as one medical director explains, “I report directly to our CEO. I was there before she was but she made me medical director right after she started. We grew into our roles together. We grow equally because we attend meetings that are beneficial to both of us. It took us several years to develop the relationship we have—a minimum of four years—but it’s great now. ... I learned how to run a clinic and she learned about providers.”

“The mission or job description gives some definition to the work so it’s not an endless ocean; when it’s more defined and aligns with the CEO, there’s a sense of control as well as moving forward together.”

Personal sources of support, such as a spouse or partner, are also very important (mean rating: 5.11). More formal types of supports offered through established organizations, including local, state, regional and national organizations, are viewed by medical directors as relatively less important.

### Most important sources of support for medical directors

(n=71)



more important

Medical directors of smaller clinics tend to rely most on their clinic peers and spouse/partner while medical directors of larger clinics cite their management team/staff as their most important source of support.

“Mentoring is crucial, as is administrative support for medical directors so they can delegate the stuff they really don’t need to be doing and actually work on more critical issues, most efficiently using their skills and the organization’s money.”

## Training and Technical Assistance

When asked about specific types of training and technical assistance that are important to their medical director role and their ongoing development, professional peers were rated as most important (mean rating: 5.06) followed by continuing medical education (mean rating: 4.48), leadership programs (mean rating: 4.37) and topical workshops and conferences (mean rating: 4.14). The least important sources of training and technical assistance are those provided by specialty societies (mean rating: 2.66) and local medical societies (mean rating: 2.45).

Medical directors commonly mention the benefits of trainings, such as the California HealthCare Foundation's Health Care Leadership Program and the Harvard School of Public Health's Managing Ambulatory Health Care Program, which played a critical role in their development by providing training on topics directly related to the leadership and management aspects of their medical director positions.

Medical directors note the importance of peer networks, which serve as both important sources of support as mentioned above as well as important sources for training. The peer networks occur in a variety of ways, including as part of leadership programs and their alumni networks as mentioned above and medical director and physician groups sponsored by CPCA and regional clinic consortia. Medical directors who lack such peer networks note their desire to be part of one. As one medical director says, "I wish there was a better network [in our area] but the one we have hasn't been very functional. The nature of the clinics is different, the cultures are different, and the clinics have a huge sense of independence."

### Satisfaction and Effectiveness in Current Position

Overall, medical directors seem satisfied in their current position (mean rating: 4.70); this is roughly the same as in the 2003 study (mean rating: 4.60). Those who are most satisfied with their current medical director position (4, 5 or 6 rating on a 6-point scale) consider their CEO to be a very important source of support.

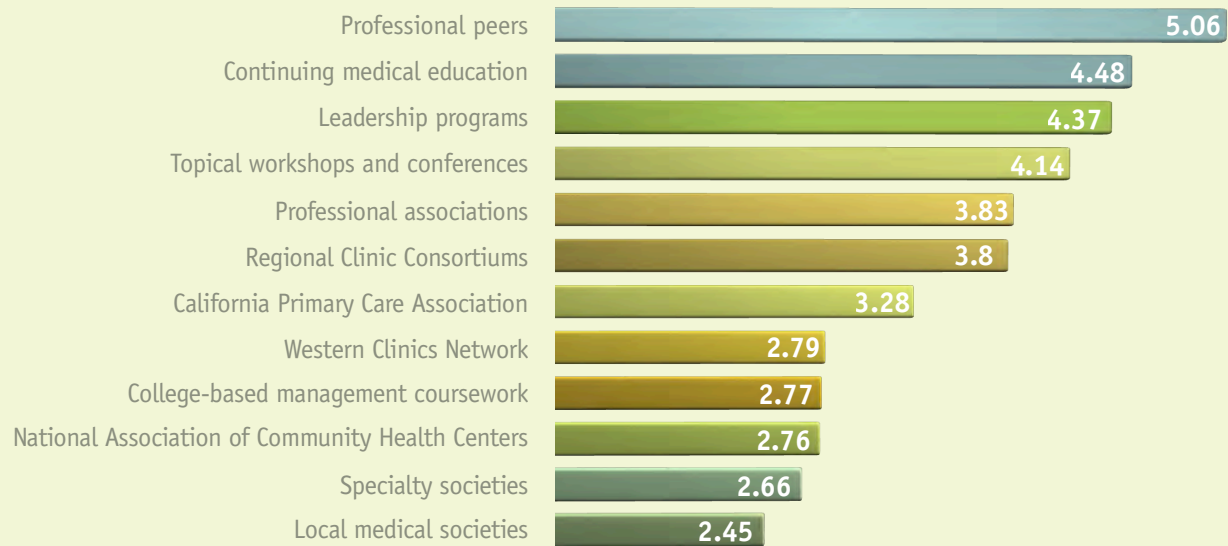
Most medical directors also report feeling effective in their role (mean rating: 4.61). Of those who feel effective in their current role (4, 5 or 6 rating on a 6-point scale), most have someone who serves as second in command and expect to remain in the position for three or more years.

"The Harvard training was very helpful. They brought in faculty members who had been in the business as medical directors for almost 30 years and had seen it all and had answers for everything. It was very good to have those people there."

Given the growing use of technology and the challenge of finding time and resources to travel, medical directors were asked about their preferred training mechanism. The vast majority of respondents (87%) prefer in-person training as compared to instructor-led Web-based or online trainings with recorded presentations; age does not appear to be a factor in choice of methods.

### Most important sources of training and technical assistance for medical directors

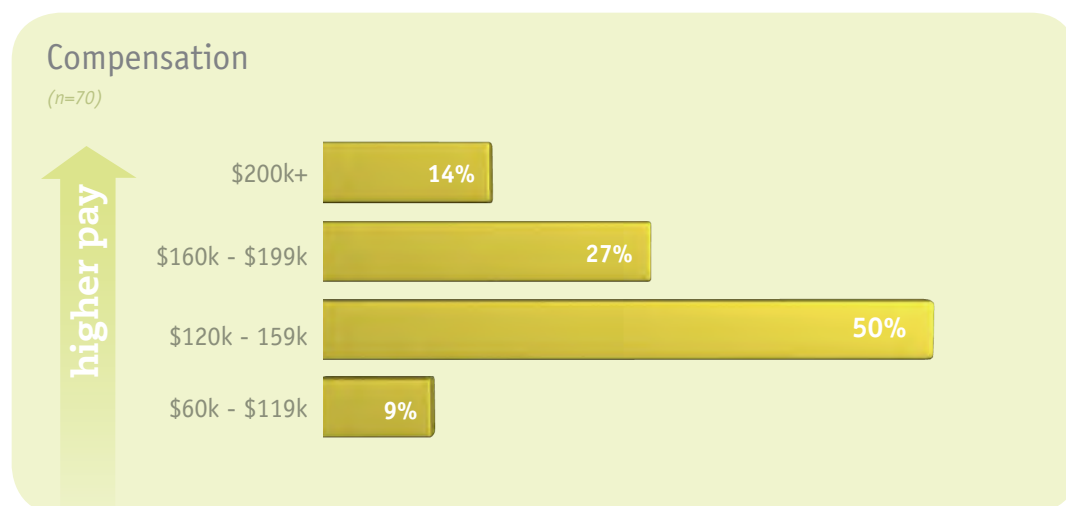
(n=71)



more important

## Compensation

Compared to the 2003 study, medical directors' salaries increased. Respondents' 5% trimmed mean salary is \$155,646 with a range from \$60,000 to \$237,000. In 2003 the 5% trimmed mean salary was \$129,581 with a range from \$31,000 to \$190,000.<sup>9</sup>



Among medical directors who annually earn less than \$120,000, most (83%) are female. Of the respondents who earn more than \$200,000, most (70%) are male. This difference may be due in part to the fact that more women are medical directors of smaller clinics and more men are medical directors of larger clinics. Medical directors with salaries closer to the average are more evenly split between males and females.

Although the majority of medical directors (65%) indicate that they have made a personal, significant financial sacrifice to work in the community clinics field, they indicate that they are relatively satisfied with their overall compensation package (mean rating: 3.94). However, the greater the extent to which medical directors report having made a financial sacrifice, the less they tend to be satisfied with their compensation.

Many medical directors indicate that they decided to work in the community clinics field knowing that they would earn less as compared to similar positions in other health care settings (e.g., private practice and HMOs), again noting the strong draw of the organization's mission. However, despite their choices about their own compensation, medical directors state that there is a point at which below market salaries preclude the recruitment and retention of medical directors. One medical director explains his rule of thumb: "If you can provide 90% of compensation demands, the other 10% can be made up by goodwill [e.g., flexible schedules, training opportunities, etc.]. If you go below 90%, you'll lose people."

Compared to clinic CEOs, medical directors' salaries are slightly higher on average; the mean CEO salary is \$122,776 with a range from \$40,000 to \$298,000. It is fairly unique in the nonprofit world to have a staff member who receives a salary higher than the most senior leader in the organization. One medical director reflects on this tension and the negative implications on retention and recruitment of medical directors and other clinic physicians, "Because clinics are run by non-clinicians, sometimes there's the view that it's too much money and they [physicians] don't deserve it."

<sup>9</sup> Both this study and the 2003 study report the 5% trimmed mean salary—a mean calculated after the top and bottom 5% of scores are removed—so that outliers do not skew the results.

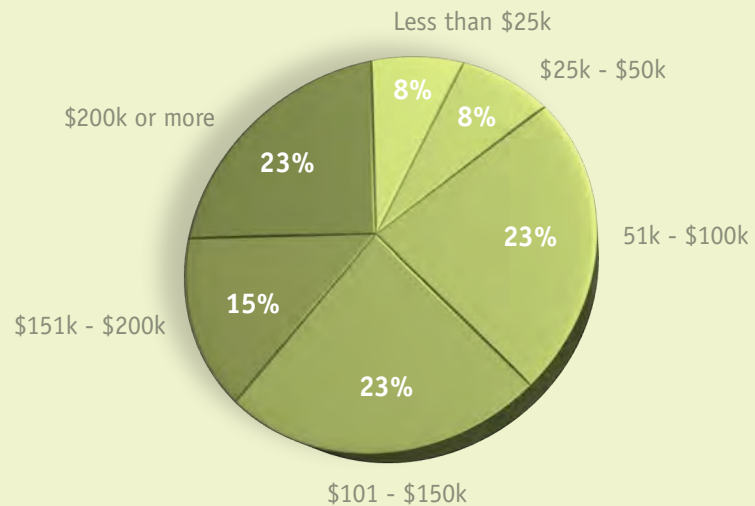
Debt from student loans is also thought to impact recruitment and retention of physicians in the community clinics field.

## Student Loan Debt

Debt from student loans is also thought to impact recruitment and retention of physicians in the community clinics field. While most medical directors (82%) in this study do not carry student loan debt, among those who do, about two-thirds (61%) carry a significant student loan balance of \$100,000 or more. All medical directors with student loan debt, regardless of the amount of debt, state concerns about the pace of paying it down, with nearly two-thirds (62%) being “very concerned.” Medical directors who carry student loan debt tend to be younger and newer to the field—between the ages of 40 and 49 and in the community clinics field for less than five years.

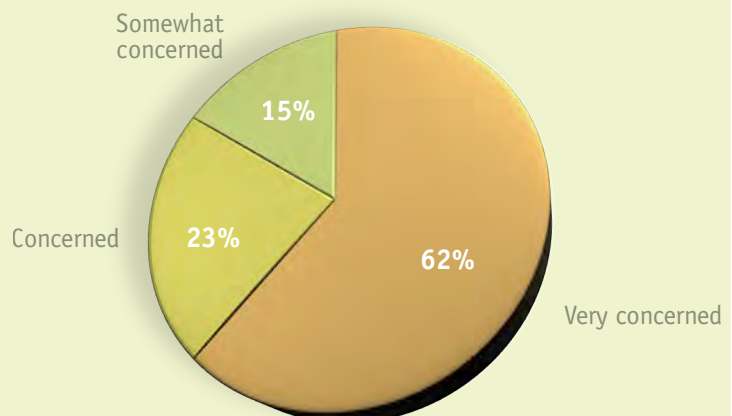
Balance of student debt remaining

(n=13)



Concern about student debt<sup>10</sup>

(n=13)



<sup>10</sup> Of those who mentioned that they have student loan debt, no one chose the answer “not at all concerned” to describe their situation.



# Medical Directors Looking Forward

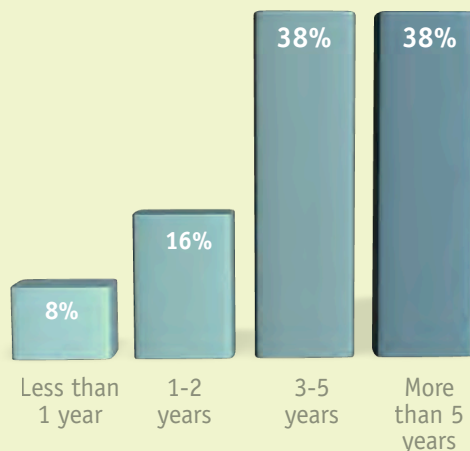
## Key Findings

- ▶ Nearly two-thirds of medical directors plan to leave their current position within the next five years.
- ▶ Only 15% of medical directors plan to assume another medical director position after they leave their current organization.
- ▶ Formal succession planning is very uncommon among medical directors.
- ▶ Many medical directors note the need for greater cultural diversity and competencies within their organizations.

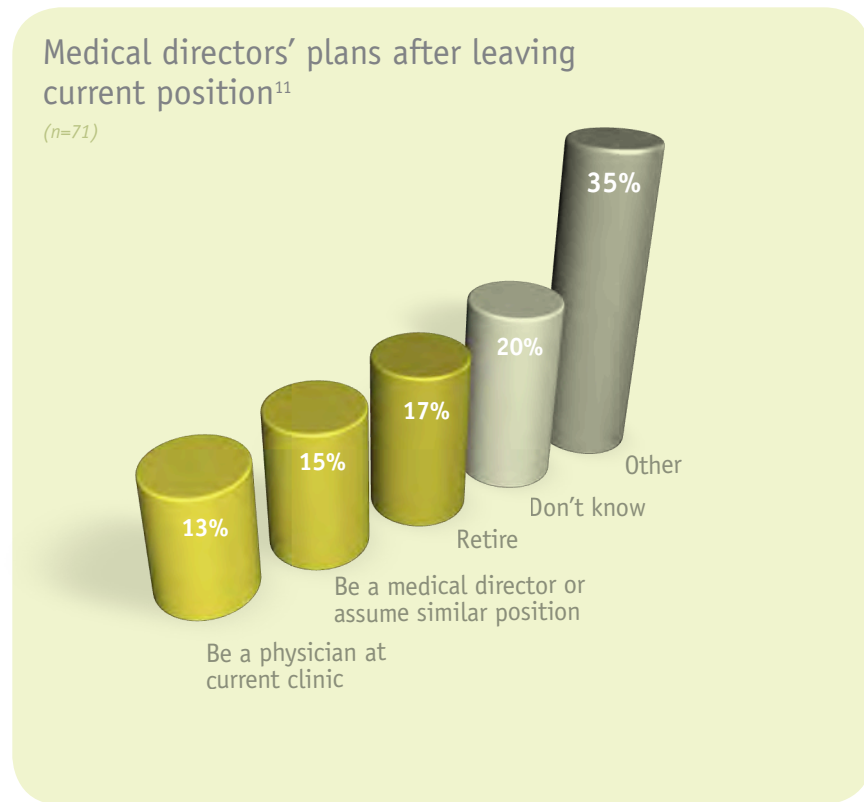
A large percentage of medical directors do not plan to stay in their positions for the long term. Almost two-thirds (62%) plan to leave their position sometime during the next five years; about a quarter plan to leave in two years or less. These estimates are similar to the 2003 medical director study and cause concern about the next generation of medical directors.

## Anticipated length of time left in current position

(n=71)



When asked about their career plans after leaving their organization, only a small proportion (17%) anticipates retiring and of those, the majority (67%) expects to stay in their current position for three to five more years. Medical directors' other career choices upon leaving their current position include being a physician at their current organization, being the medical director at another clinic, or taking another type of position (e.g., philanthropy, academia, consulting); one-fifth of medical directors do not know what they plan to do upon leaving their current position. Respondents' choices for their next career move are similar to those in the 2003 study.



11 "Other" choices for next career move reported by medical directors include: philanthropy, academia and consulting.

## Ability to Retire

Slightly more than half (51%) of medical directors do not feel that they will be able to retire when they want to do so. Those who will be able to retire when they desire are fairly evenly split between age groups: 40 to 49 (29%), 50 to 59 (27%) and 60+ (26%); fewer respondents who feel they will be able to retire on schedule are under age 40 (18%). Medical directors think they will not be able to retire when they desire primarily due to a lack of financial resources, including insufficient retirement savings and general poor economic conditions. Those who will be able to retire on schedule cite sufficient savings as the most common reason for being able to do so; other reasons include personal supports and having identified a successor.

## Succession Planning

When asked about cultivating future medical directors, and specifically whether they have explicitly identified someone to be the next medical director, only 9% report doing so. Of those medical directors whose organizations have not explicitly identified someone, most (78%) expect to remain in their current position for three or more years, which suggests adequate time to plan for a successor.

Of organizations that have explicitly identified the next medical director, most (83%) identified someone within their organization. Of those internal successors, all are currently staff members (as opposed to board members or volunteers) with most (80%) being the current associate medical director.

## Cultural Diversity and Competencies

To achieve their mission to provide high quality care, medical directors think it is important to take into account the degree to which the cultural diversity and competencies of the staff reflect the patient populations that they serve; this is especially true for those who provide direct clinical care. When asked the extent to which medical directors think that their organization pays attention to cultural diversity when recruiting, hiring and promoting staff, most thought that they paid a good deal of attention to this issue (mean rating: 4.72); this, however, did not directly correspond to successes.

Most medical directors who made specific comments about the cultural diversity of their staff think that their staff are sufficiently diverse; in fact, some even claim that their staff “is more diverse than [their] patients.” Other medical directors, however, believe that their staff “needs to be a little more diverse,” but lament about the “limited pool to recruit from.” Medical directors also state the need to enhance cultural competency of staff, regardless of their cultural background and experience. They note the importance of activities such as cultural competency trainings for staff, and the use of translators and multi-lingual materials for patients.

While medical directors overall are more diverse than their counterparts in CEO positions (41% identify as other than “White/Anglo” as compared to 32% of CEOs), the shift in diversity among medical directors has remained fairly constant over time, with significant underrepresentation of certain groups such as Latino/as. While the pipeline of potential candidates for future medical directors appears to have greater diversity, more intentional efforts are warranted to ensure the attractiveness of the position.

Only 9% of medical directors have explicitly identified someone to be the next medical director.

# Calls To Action

In this section we make some recommendations based on the study findings and their implications. These suggestions are directed to those individuals and groups who hold key positions to support the recruitment, development and retention of medical directors for California's community clinics and clinic consortia including: medical directors themselves; the CEOs of organizations where they work; funders; and capacity builders (e.g., statewide and regional community clinic associations, training programs and consultants).



## For Medical Directors

### Plan your own professional development and career path.

- As part of your annual review, assess your own professional development needs and career plans to identify short- and long-term goals and the supports necessary for accomplishing them; take into account the ways in which your plans align with those of the organization.
- Pay special attention to the knowledge and skills critical to the medical director position for which you lack training or experience.
- Contribute to a medical director model that is sustainable and attractive to others by asking for what you need to be effective in your position and working to secure it.

### Participate in peer networks with other medical directors.

- Identify relevant peer networks that allow you to obtain input and support from other physicians who hold similar positions.
- Consider the variety of peer networks that can be accessed through clinic-related groups including CPCA, the regional clinic consortia and leadership programs and their alumni networks.

### Contribute to a model of shared leadership within your organization.

- Building on your shared commitment to your organization's mission, partner closely with your CEO on key management functions; consider both internal and external activities in which medical director involvement is typically lower (e.g., fundraising and public policy/advocacy) but could benefit from your involvement.
- Be creative in determining the shared model of leadership that addresses the specific capacities and needs of your organization.

### Broaden the bench strength of clinicians within your organization.

- Consider different models of sharing administrative duties among clinicians to help balance your own administrative and clinical duties, enhance your job satisfaction and effectiveness, and cultivate future medical directors (e.g., co-medical directors or associate medical directors who oversee specific programs).
- Pay special attention to those who may be well-suited for medical director responsibilities; however, don't overlook "strong physicians" who may not be suited for a medical director position, but can play a key leadership role on the clinical management team.

## For CEOs

### **Partner closely with and ensure needed support for your medical director.**

- Check in regularly with your medical director to ensure that s/he has the supports to do his/her job effectively; in doing so, offer ongoing opportunities for professional growth and sustainability in the medical director position.
- Work closely with your medical director on key management functions; proactively determine and plan for ways in which the responsibilities for specific functions will be shared and take into account those functions in which medical director involvement would benefit their own development and the organization.
- Attend relevant meetings and trainings together including those that specifically focus on CEO and medical director partnerships (e.g., leadership training for CEO/medical director pairs) as well as those in which your joint participation could benefit the clinic's work and your own networks (e.g., providing testimony at a local meeting of elected officials).

### **Support a model of shared leadership with your medical director and other organizational leaders.**

- Make sure that your medical director has opportunities for “real” participation and decision making as a member of the senior management team; ensure that team members know and appreciate the specific opportunities and challenges of each other's positions.
- Work with your medical director to determine how often and in what ways to be involved with the board.
- Assist your medical director, as needed, with establishing a model of shared leadership for the organization's clinical management team, including securing a second in command.

### **Plan for and cultivate future medical directors and other clinical leaders.**

- Work with the medical director to determine ways to mitigate challenges around recruitment, management and retention of clinical staff.
- Collaborate with others to broaden the organization's recruitment efforts; utilize your own networks to identify and introduce physicians and other clinicians to your organization (e.g., through volunteer opportunities, as board members or donors).
- Work with your medical director to increase the bench strength of clinicians who can take on medical director responsibilities in the case of his/her temporary or permanent absence.
- Promote the importance of the medical director position, including the administrative responsibilities, to the success of the organization in fulfilling its mission.

### **Contribute to adequate supports to develop and retain medical directors.**

- Address the need for competitive compensation packages and other types of incentives to make the medical director position attractive and sustainable.
- Provide flexible monetary and non-monetary supports that can be tailored to address the individual and collective needs of medical directors, their organizations and the broader field; allow for adjustments as capacities and needs shift.
- Ensure that these supports promote shared leadership within and across organizations and build on/leverage existing supports (e.g., through statewide and regional clinic associations and leadership programs).

### **Support system-wide efforts to foster strong medical director leadership and develop an adequate pipeline for the future.**

- Provide support for capacity builders' participation in leadership and workforce development efforts that cross the health care, education and workforce sectors.
- Support workforce-related policies and regulations that can positively impact the decision of medical students to become primary care physicians and enter and remain in the community clinics field.
- Fund research that highlights key problems and solutions to address leadership and workforce needs within the community clinics field, including those directly related to medical directors (e.g., salary benchmarking and best practices in regard to the recruitment, development and management of medical directors).

*For Funders*

## For Capacity Builders

### **Provide a variety of supports to address the different needs of medical directors.**

- Ensure that supports take into account the varying tenures of medical directors; for example, a physician who is new to the medical director position needs different supports as compared to a well-seasoned medical director who may desire more advanced leadership challenges.
- Utilize existing trainings both within and outside of the community clinics field, only creating new ones as needed; focus limited funds on geographic areas in greatest need of support (e.g., rural) or medical directors' skills in greatest need of improvement (e.g., lack of training in management skills).
- Consider one-on-one supports for medical directors (e.g., mentors and coaches) that compliment those delivered to groups (e.g., off-site trainings and peers networks); one-on-one support can be especially important for those who are new to their positions, lack adequate internal or external supports, face a significant challenge and/or are considering a position shift.

### **Promote shared leadership throughout the organization.**

- Provide support to promote joint leadership development among CEOs and medical directors, senior leadership teams and clinical management teams.
- Identify and share different models in which medical directors partner with CEOs and share administrative responsibilities among their clinical staff; this may involve new ways of thinking about and providing leadership development (e.g., off-site group training of clinical staff with coaching to implement changes at the organization).

### **Identify and promote incentives for current medical directors to stay in their positions, move to other positions within the community clinics field and increase the number of physicians who consider taking a medical director position.**

- Given the large percentage of medical directors who plan to leave their position or the community clinics field in the near future, it is important to identify and determine supports that may incentivize them to stay (e.g., new leadership challenges, retirement packages, flexible schedules); at the same time, promote succession planning, especially among those who definitely plan to leave their position in the short term.
- When encouraging physicians to enter the community clinics field and/or take on a medical director position, emphasize the benefits of entering and staying in the field (e.g., making a difference in the community, mission of clinics, loan payback programs).
- Take a field-wide approach to helping physicians determine their next steps, supporting them whether they take a position as a medical director within their own organization or move to another organization with the community clinics field.



# Resources

*"Securing the Safety Net,"* Jeanne Peters, Catalina Ruiz-Healy and Kara Vassily. CompassPoint Nonprofit Services, 2003. [www.compasspoint.org](http://www.compasspoint.org)

*"Bridging Management and Medicine,"* Catalina Ruiz-Healy, Jeanne Peters and Kara Vassily. CompassPoint Nonprofit Services, 2003. [www.compasspoint.org](http://www.compasspoint.org)

*"Daring to Lead 2006: A National Study of Nonprofit Executive Leadership,"* Jeanne Bell, Richard Moyers, Timothy Wolfred and Natasha D'Silva. CompassPoint Nonprofit Services and The Eugene and Agnes E. Meyer Foundation, 2006. [www.compasspoint.org](http://www.compasspoint.org)

*"Ready to Lead?: Next Generation Leaders Speak Out,"* Marla Cornelius, Patrick Corvington, Albert Ruesga, Suman Murthy and Nick Turner. CompassPoint Nonprofit Services, The Annie E. Casey Foundation, The Eugene and Agnes E. Meyer Foundation and Idealist.org, 2008. [www.compasspoint.org](http://www.compasspoint.org)

*"Building Leaderful Organizations: Succession Planning for Nonprofits,"* Timothy Wolfred. CompassPoint Nonprofit Services, 2008. Commissioned by The Annie E. Casey Foundation. [www.compasspoint.org](http://www.compasspoint.org)

*"The Nonprofit Sector's Leadership Deficit: Executive Summary,"* T. Tierney. Boston: The Bridgespan Group, 2006. [www.bridgespan.org](http://www.bridgespan.org)

*"Managing Executive Transitions: A Guide for Nonprofits,"* Tim Wolfred. Saint Paul: Fieldstone Alliance, 2009. [www.compasspoint.org](http://www.compasspoint.org)

*"Coaching Skills for Nonprofit Managers and Leaders: Developing People to Achieve Your Mission."* M. Gislason and J. Wilson. San Francisco: Jossey-Bass, 2009.

# About

**BTW informing change (BTW)** is a strategic consulting firm that provides evaluation and organizational learning support to philanthropic and nonprofit organizations. BTW strives to inform change in the nonprofit and philanthropic sectors by working in partnership with clients to design and implement evaluations, assist with program and organizational planning and conduct applied research. To find out more about BTW, visit [www.btw.informingchange.com](http://www.btw.informingchange.com).

**CompassPoint Nonprofit Services (CompassPoint)** is a nonprofit consulting, education, and research organization with offices in San Francisco and Silicon Valley, California. Through a broad range of services and initiatives, CompassPoint serves nonprofit volunteers and staff with the tools, concepts, and strategies necessary to shape change in their communities. In addition to training and consulting in leadership, nonprofit strategy, finance, fundraising, governance, and executive transition management, CompassPoint frequently publishes books, articles, and research reports on topics of relevance to nonprofits, funders, and capacity builders. For more information, visit [www.compasspoint.org](http://www.compasspoint.org).

**Blue Shield of California Foundation** is committed to making health care effective, safe, and accessible for all Californians, and to ending domestic violence. As one of California's largest health philanthropies, the Foundation serves as a catalyst for change, promoting new solutions and bringing together a diverse array of stakeholders. The Foundation blends community-based philanthropy with strategic innovation to move California forward. To learn more, visit [www.blueshieldcafoundation.org](http://www.blueshieldcafoundation.org).

**The Community Clinics Initiative (CCI)** is committed to attaining health equity for traditionally underserved communities in California through field building, collaboration, learning and reflection. CCI is a joint project of Tides, a San Francisco-based nonprofit organization that works with "individuals, groups and funders to implement programs that accelerate positive social change" and The California Endowment, a statewide health foundation whose mission is to "expand access to affordable, quality health care for underserved individuals and communities, and to promote fundamental improvements in the health status of all Californians." For more information, visit [www.communityclinics.org](http://www.communityclinics.org).

*The following organizations' medical directors participated in a focus group or an interview in June and July, 2009:*

Dr. Mark Apfel, Anderson Valley Health Center

Dr. John Silva, Clinica de Salud del Valle de Salinas

Dr. Robert Moore, Community Health Clinic Olé

Dr. Mark Sears, Haight Ashbury Free Clinics

Dr. Dawn Harbatkin, Lyon Martin Health Services

Dr. Ricardo Alvarez, Mission Neighborhood Health Center

Dr. Neal Rendleman, Mission Neighborhood Health Center  
HIV/AIDS Clinic

Dr. Shannon Cheffett, Mountain Health and  
Community Services

Dr. Thang Nguyen, Native American Health Center

Dr. Kenneth Tai, North East Medical Services

Dr. Mary Gatter, Planned Parenthood Los Angeles

Dr. David Lown and David Offman, San Francisco  
Community Clinic Consortium\*

Dr. Peter Berman, South of Market Health Center

Debby Davidson, Women's Community Clinic\*\*

\* In addition to the medical director, a consultant from SFCCC also participated.

\*\* A nurse practitioner participated on behalf of the Women's Community Clinic medical director.

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*For more information about this report, contact Kim Ammann Howard at [kahoward@btw.informingchange.com](mailto:kahoward@btw.informingchange.com). An electronic copy of this report is available at [www.btw.informingchange.com](http://www.btw.informingchange.com).*

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