



Physician Organization Governance: Transformation and Three Perspectives



Introduction

Spurred by the passage of the Affordable Care Act (ACA), the health care field has been moving forward in redefining what it means to be a hospital. In addition to expanding coverage, the ACA also called for a number of pilot programs to redefine care delivery, allowing providers to experiment and think more broadly about the move from volume to value-based care delivery. As the field moves toward more integrated and accountable care, existing silos and divisions will need to come down to allow for coordinated efforts to manage the health of populations.

The field's vision of overall transformation includes all providers joining together to take responsibility for populations, better coordinate across care settings and providers, more effectively manage chronic disease, and take a greater role for primary care.

To support the field in these transitions, the AHA is working with the American Medical Association (AMA) to identify principles of integrated leadership. The principles were released in 2015 and can be found at www.ahaphysicianforum.org/integratedleadership.

The principles focus on the need to develop a structure with collaborative and integrated leadership between clinicians and the hospital leadership. The principles emphasize the need for physician and hospital leaders with similar values and expectations, aligned incentives and goals as well as shared responsibility for financial, cost and quality targets and a shared focus on engaging patients as partners in their care.

Further, the principles call for an interdisciplinary structure that supports collaborative decision-making between physicians and hospital executives at all levels of the integrated health system. This collaborative,

participatory partnership must be built on trust with a sense of interdependence and working towards mutual achievement of the Triple Aim. That trust is developed by open and transparent sharing of information to improve care and supported by a robust clinical information system.

To work effectively as partners in this type of model, more coordination between hospitals and clinicians is needed, as well as greater organization of physicians into effective, accountable groups that can manage care across the continuum. Key among the organizational principles of a physician organization is an inclusive governance process that examines performance of the group, membership requirements, establishes leadership and manages how resources are used. The group also must be able to create strategy, a future vision and have resources underpinning them.

Governance of Physician Organizations

To understand how the governance of physician-led organizations is different, and similar, to that of health care systems, the AHA's Center for Healthcare Governance and Physician Leadership Forum, with generous support from Hospira Inc., undertook a study to examine governance structures and functions in a diverse set of physician organizations—entities designed to engage physicians in the leadership, governance and decision-making of the clinical care enterprise. The resulting report, *The Blue Ribbon Panel on Governance of Physician Organizations*, examines how physician organizations govern themselves, how they come together as groups and how they impart the discipline and get the outcomes they need to be successful.

The study aimed to understand what governance practices currently exist among physician groups. Thirty-one physician leaders, executives and board members of six organizations were interviewed and shared their insights. The organizations studied included: Advocate Physician Partners, Downers Grove, Ill.; Billings Clinic, Billings, Mont.; East Bay Physicians Medical Group, Lafayette, Calif.; Hill Physicians Medical Group, San Ramon, Calif.; Hospital Sisters Medical Group, Springfield, Ill; and Memorial Hermann Physician Network (MHMD), Houston.

In follow up to the report, the AHA convened an educational session to share highlights of the study and provide an in-depth examination from three leading-edge case studies.

Key Learnings and Gaps Identified in Physician Governance

John R. Combes, M.D., chief medical officer and senior vice president, American Hospital Association, welcomed session participants and set the stage for the program by sharing the findings of *The Blue Ribbon Panel on Governance of Physician Organizations*.

As Dr. Combes explained, the study shows physician organization governance drives value for patients and health care organizations by championing a relentless focus on quality, safe, cost-effective care, fulfilling a vision of providing the highest quality care and a commitment to being the best at delivering care. Governance can impede organizational success when there is a failure to engage in crucial conversations, being perceived as self-serving and failing to base decisions on data and evidence.

Challenges for physician organizations include transitioning from fee-for-service to fixed payment, governance oversight and setting strategic direction in an environment with many unknowns, assumption of clinical risk to drive assumption of financial risk, and lack of alignment and trust between physician organizations and hospitals and health systems.

Additionally, difficulties arise due to lack of understanding of differences between governance and management as physicians are often involved at both levels, lack of definition of relative roles, responsibilities and authorities among boards and management, such as who hires and fires the physician organization CEO, and lack of self-reflection on board capabilities to drive improved governance.

Most of the study boards are structured with the key committees needed to achieve successful governance oversight, appropriately dividing work between the committees and the board. However, committees were not broadly used to diversify the board's perspective, since most of the committees are composed of board members rather than outside expertise. Finally, the boards often struggled to refrain from becoming operational and getting involved in management matters.

The organizations that took part in the study demonstrated strong focus on quality and delivering safe care. Physician board members prepared for and actively participated in meetings, and there was a willingness to share dissenting opinions. Study participants also showed strong investment in developing physician leaders to assume governance roles.

The nature of health care is changing. Boards must move beyond being only fiduciary responsibility, think differently and ask the generative questions such as ‘what is our purpose?’ Leaders can change the focus of care across the system, recognizing it takes partnership of clinicians and executives to move toward population health.

Keynote: Governance Models in a Transforming Delivery System

Based on the findings of *The Blue Ribbon Panel on Governance of Physician Organization* supporting the need for strong physician organization governance, JoAnn McNutt, Ph.D., Nygren Consulting, provided six essential tools for effective governance of physician organizations.

Dr. McNutt, an expert in board governance, first discussed key themes in the transformation of governance models. In her work, Dr. McNutt has seen an increase in mergers and acquisitions as well as affiliations and partnerships that are creating larger systems of equals working together to effect change.

These collaborations and affiliations are becoming more common as the health care delivery environment changes, in part as a result of the ACA. As the field evolves, governance must grow and change to provide the best direction for new models. For organizations to truly address population health, they need to determine what the board’s work should consist of and define the key roles and responsibilities.

The mission, vision and values of an organization inform the strategy for governance. Once the mission, vision and values have been identified as the work of the board, an organization needs to determine what competencies are needed. Boards are looking for leaders with needed competencies who also understand population health. Physicians can provide

needed expertise in clinical risk, quality and patient experience to begin to address population health.

As governance evolves, boards need to be able to govern themselves before they can govern an organization. Until the board understands its roles and responsibilities and what governance is, it will not be able to effectively govern an organization. To govern well, a board must determine what is working well, what is not working well, and what can be done differently.

The core responsibilities of the board has evolved in recent years. Board governance used to consist of the hiring and firing of the CEO, financial oversight and strategy. Responsibilities expanded to establishing and upholding the mission, vision and values, CEO succession and executive compensation. Enterprise risk management, clinical risk, ethics and compliance also have come under the board’s purview, and finally, quality, patient experience and population health.

According to Dr. McNutt’s observations, good governance boils down to three things: what is done in the board room, who is in the board room, and what happens outside the board room. What gets done in the board room is strategic oversight, financial oversight, policy setting, priority setting, decision-making, accountability and committee work. When determining who is in the board room, organizations need to consider competencies and diversity—reflecting the community being served as well as the mission, vision, values and strategy.

Once boards have determined what gets done in the board room and who is present, high-performing boards are able to address what occurs outside of the board room including: communicating with fellow board members, management and stakeholders; building relationships; maintaining confidentiality; managing crisis; being ambassadors of the organization; and developing leadership within the board and executive team.

As mergers and acquisitions, affiliations and partnerships happen, confidentiality is especially important as information leaks can be problematic. Having a compact defining roles and responsibilities and addressing confidentiality can ensure the board acts as a unit. In addition, boards need to be intentional about how they relate to the executive team. With an effective process

in place, board members can be deliberate about how they ask the management team for information.

Six Essential Tools for Effective Governance of Physician Organizations

Dr. McNutt provided six tools to create a high-performing effective board; these are a strategic roadmap, authority matrix, decision-making policy guideline, board competency profile, director self- and peer-assessment and a board member code of conduct.

Strategic Roadmap

A strategic roadmap, alternatively referred to as a strategic plan or direction, is a tool boards can use to be clear about the vision, mission and purpose of the organization. The vision, what an organization hopes to be, needs to be audacious yet attainable.

A strategy statement is typically internal and sets forth benchmarks the organization wants to achieve within a certain time frame. Priorities are established based upon the statement, distilling the strategy into external and internal foci. Each area of focus has specific goals and outcomes, as well as approaches and tactics, measures and timelines. This tool provides a single page summary of what the organization’s purpose is, what it does, and what it strives to achieve. Everyone in the organization should be able to see themselves in the summary. (Figure 1)

Authority Matrix

The authority matrix addresses potential miscommunications by answering questions and clarifying responsibilities. It is important to capture all stakeholders in the matrix, including the executive leadership team, committees, the board, a system board, and anyone else with an investment and interest in operations. The development of the matrix will clarify authority and identify exactly where decision-making occurs.

The authority matrix includes the mission, vision, values and strategy as well as the major decisions the board will address. Policy decisions can be included as well as finance and investment transactions.

The process of completing the matrix through discussion and debate allows all involved to participate and understand their roles. (Figure 2)

Governing Through Policy Setting

Good boards govern through policy setting. Policy levels may be broken down into major, secondary, functional, minor and standard operating procedure. Establishing levels at which decisions are made allows boards to be more efficient. Knowing at what level a matter ought to be discussed can save the board time and energy addressing an issue that should be decided elsewhere. (Figure 3)

American Hospital Association
Center for Healthcare Governance

NYGREN
CONSULTING

Strategic Roadmap

Mission	Our mission is to...					
Vision	We will...					
Values	Our core values include...					
Strategy Statement <i>What is our go-forward plan?</i>	By 2020, we will...					
Priorities <i>What will we focus on?</i>	Area of Focus #1 (External)			Area of Focus #2 (Internal)		
Goals / Initiative <i>What are the initiatives that will get us there?</i> <i>What are the desired outcomes?</i>						
Approach <i>How will we achieve those goals and outcomes?</i>						
Measures and Timeline <i>How and when will we measure our progress?</i> <i>What does success look like?</i>						

Figure 1.

Decision Authority Matrix

	Executive Leadership	Committees	Board of Directors	Parent or Sponsor Board
Mission and Purpose				
• Changes to the mission, purpose, vision, brand, logo, name or identity of the system	Develop/Propose		Review and Recommend	Approve
Major Transactions/Decisions				
• Sale/merger/dissolution or substantial change of assets	Develop/Propose	Finance Committee to Review and Endorse	Review and Recommend	Approve
• Sale/merger/dissolution or substantial change of assets of affiliates	Develop/Propose	Finance Committee to Review and Endorse	Review and Recommend	Approve
• Financial assessment of major proposed transactions, new programs and services and proposals to discontinue programs or services	Develop/Propose	Finance Committee to Review and Endorse	Review and Recommend	Approve
Strategy				
• Changes or updates to the strategy	Develop/Propose	Strategic & Long Range Planning Committee to Review and Recommend	Review and Approve	
• Long-term strategic direction and goals	Develop/Propose	Strategic & Long Range Planning Committee to Review and Recommend	Review and Approve	
• Geographic expansion	Develop/Propose	Property Committee to Review and Recommend	Review and Approve	

Figure 2.

Board Competency Profile

A board competency profile is developed after determining what the work of the board is, assessing what is needed to ensure good governance and what competencies are needed. Competency profiles can be created for the entire board or by specific committee. Usually handled by a governance committee, a competency profile should assess whether collectively the board is strong in specific needed areas rather than address individual competencies. (Figure 4)

Director Self- and Peer-Assessment

Some organizations complete director self- and peer-assessments annually utilizing results to drive improvement. Others use assessments to determine board members' fitness for re-election. The assessment could be as simple as three questions: What is this director's most significant individual strength? What are areas for development? And, would you recommend the director for re-nomination to the board?

The goal of assessment is to ensure the right leaders are involved, are asking the right questions, and challenging management to effectively fulfill the mission, vision and values of the organization.

Board Member Code of Conduct (or Board Compact)

A code of conduct, or compact, is a tool to set expectations and clarify consequences. A board should be proactive and govern by intention, not by consequence. It is essential to establish board and committee participation in the compact. A compact also can address confidentiality, information requests, communication, crisis management, ambassadorship and education expectations. The board should have robust conversations about what items the compact will include. Some organizations have physician and management compacts as well as board compacts, and some combine all three. For example, the board may promise management to ask for the right information, and management may in turn promise to provide effective analysis of data. Once in place, all of these tools need to become part of the board's function and their performance assessed and improved as needed. As a learning organization, the board must lead the constant evolution to becoming a high-performing, effective board.

Governing Through Policy Setting



Adapted from: Chait, R. P. and Taylor, B. E. (1988) Charting the territory of nonprofit board. *Harvard Business Review*.

Figure 3.

Board Competency Profile

	General Core Competencies for all Board Members					Committee-Specific Competencies					
	Service on a Board of Directors or Board Committee	Knowledge in Physician Integration and Care Integration	Knowledge in Healthcare Advocacy, Public Policy, Community Benefit	Knowledge/ Experience in Technology and Information Systems	Knowledge/ Experience as a Healthcare Professional	Compensation	Compliance and Audit	Governance	Quality	Finance	Investment
Director Scores	4	4	4	4	4	3	3	4	4	3	3
	4	3	3	3	4	3	3	3	3	3	2
	3	3	2	3	0	2	1	2	3	2	2
	2	2	2	2	0	2	1	2	3	2	1
	1	1	1	1	0	2	0	1	1	1	0
Average	2.8	2.6	2.4	2.6	1.6	2.4	1.6	2.4	2.8	2.2	1.6
Overall Average 2.3	Relative Strength	Relative Strength	Average	Relative Strength	Relative Weakness	Average	Relative Weakness	Average	Relative Strength	Average	Relative Weakness

Figure 4.

Three Perspectives: Physician Organization Governance

Memorial Hermann Physician Network (MHMD)

D. Keith Fernandez, M.D., former president and physician-in-chief of MHMD, the Memorial Hermann Physician Network, and former chief medical officer of the Memorial Herman Accountable Care Organization in Houston shared the MHMD governance model.

Founded in 1982 and formerly known as Memorial Hermann Health Network Providers, MHMD is a clinically integrated, for-profit, multispecialty, independent physician organization of more than 3,000 doctors in the greater Houston area serving 350,000 patients. It is the primary physician network for Memorial Hermann Healthcare System (MHHS) which includes 12 hospitals, 19 ambulatory surgery centers and an accountable care organization. MHMD is comprised of private, independent primary care and specialist physicians as well as physicians on the faculty of the University of Texas Medical School at Houston.

MHMD originally had a small, non-elected board, the members being the individuals who started the independent physician association. Board members began to be elected, but the board was dysfunctional, with everyone representing either their hospital or specialty. Few accomplishments were achieved. This evolved into a representative board by medical staff size, which was even less effective. Governance began to improve once it became an appointed representative board. Currently, there are nine members nominated by membership and each hospital campus medical executive committee (MEC), and 13 who are appointed by the board. There is a board nominating committee that screens all potential board members based on their qualifications.

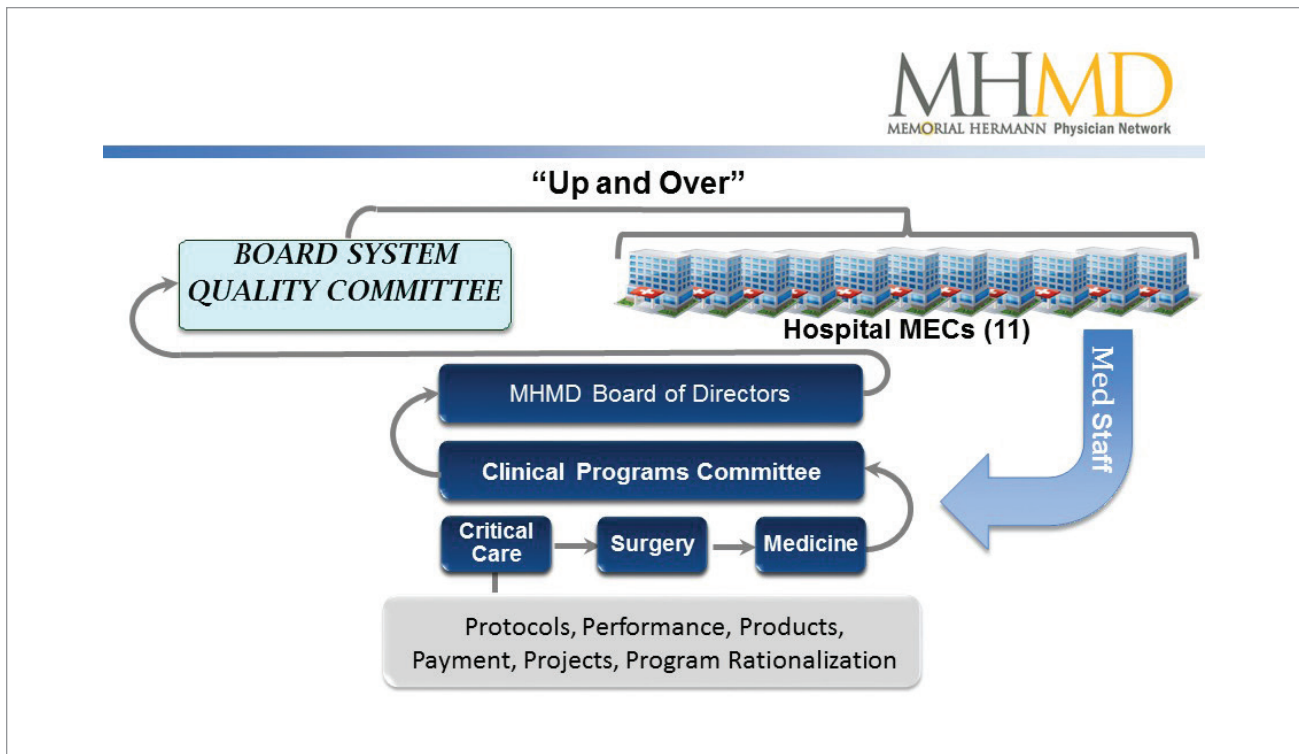
MHMD's governance success has been due in large part to education about governance and a physician's role in governance, both of which are critical to establishing a common vision. MHMD developed a

partnership with Rice University to create a five-month certificate program for physicians and administrators.

Another critical component to the physician group's performance is the compact MHMD developed. The compact states that MHMD leadership agrees to provide excellence, governance and transparency; accountability to collaborate with physicians to achieve quality and efficiency goals; to demonstrate compassion and respect; to foster team spirit; and, to support innovation. Physicians, in turn, agree to practice evidence-based clinical care, be transparent, collaborate with MHHS to improve safety and efficiency, demonstrate compassion and respect to patients, other physicians and health care professionals, be accountable, function as a member of the MHMD team, and support innovation. The compact is a tool with which to measure performance and a means to hold one another accountable.

Holding one another accountable and trusting one another in decision-making is evident in delegation of authority. Each specialty and sub-specialty reports to a Clinical Programs Committee (CPC), which then reports to the board. The CPC is delegated authority from the system quality committee to put in place care protocols across the system. In addition, there are task-oriented committees, as well as five vendor committees that now run the supply chain for the health system. More than 400 physicians serve on these committees, attending 75 percent of the meetings. The CPCs connect to the system board and the MECs.

Another factor in the success of MHMD is the utilization of data. Doctors meet every quarter to review their quality and cost data. Physicians review reports for quality metrics, per-member, per-month scorecards, outlier reports as well as patient and physician profiles. Data and rankings are shared unblinded, which fosters unity and cohesiveness across the physician community. Resources are available to facilitate improvement.



Good governance is critical and can be expanded from a board to specialties, sub-specialties and supply chains. Empowering physicians as part of governance allows them to understand how to deliver on the Triple Aim of better health, better health care and lower cost.

Billings Clinic

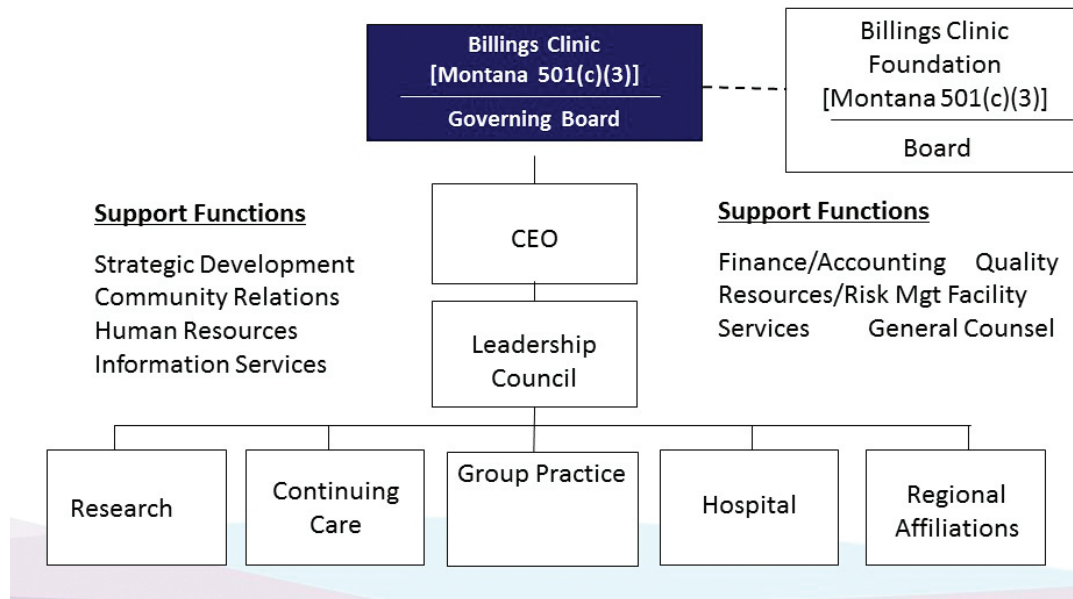
J. Scott Millikan, M.D. is a practicing cardiovascular surgeon at Billings Clinic, Billings, Mont. where he has been an active leader for many years, serving as a member of the Board of Directors since 2005. Dr. Millikan recently completed a term as chairman of the board of directors and is now chairman of the Department of Cardiac, Thoracic and Vascular Surgery. Dr. Millikan described the governance journey at Billings Clinic as one of going from a private multi-specialty group practice to a fully integrated health care system. Along the way, physician leadership has been encouraged and important lessons have been learned.

Billings Clinic was founded in 1917. The hospital that Billings Clinic eventually integrated with, Billings Deaconess Hospital, was built in 1927. In 1989 the

Billings Clinic partnership was 90 physicians, representing 85 percent of the admissions to Deaconess Medical Center. Merger discussions began in 1989 and eventually the two merged in 1993. The merger happened because the physician group needed capital and income stabilization while the hospital was worried the group practice might move services out of the hospital. There were infrastructure inefficiencies and a need to minimize duplication of services. Upon merging, the vision and culture were established. Once merged, the parent board was formed, but the hospital and clinic were maintained as separate business entities.

At the time of the merger, rather than a single CEO, responsibilities were shared between the hospital CEO, a clinic physician CEO and an administrative manager. This leadership approach had its challenges and ultimately was changed. The board also started as a merged entity with a lack of clear direction and expectations. Divisions between hospital and physician members of the board and differing expectations and perceptions became clear. Physicians thought the merger was a partnership and a chance to embark on

Medical Foundation Model



a new relationship similar to Virginia Mason Clinic or Mayo Clinic. Many on the hospital side viewed it as an acquisition of a group practice.

These differing ideas ended with mediation. Management was changed to a co-CEO model for a time. In 1997, Billings moved to a single CEO and single unified budget. Comparisons and infighting were curtailed and the work of building a unified board and vision began.

Over time, Billings Clinic has become financially stable, and physician recruitment has improved with significant investment in physician leadership development. Centers of Excellence have been developed, as well as a greater regional strategy, operating plan, balanced scorecard and market share movement.

Billings Clinic is a medical foundation model. There is a Billings Clinic board and a charitable foundation board. There are 12 members on the community-based board. It is representational in that two physician positions are elected by the physician body. Physicians serving on

the board, though, are not there to represent physicians, but provide a medical perspective. There are also nurses on the board who are not employed by the hospital or health system.

Many believe that physicians can't help but represent their own self-interest. Billings Clinic has proved this statement to be false. The board looks to the physicians for clinical expertise and understanding of the functions of care delivery and feels that having physicians on the board is very beneficial.

The CEO also sits on the board, and is a physician. The bylaws state that the CEO must be a physician. An operating council was established, called the Leadership Council. The Leadership Council consists of seven physicians who are elected by the physician body and seven administrators. Three of the seven administrators are also physicians, the CMO of the hospital, the CMO of the clinic and the chief quality officer. There is a close relationship between the Leadership Council and board. The Leadership Council

members often attend board meetings. Feeding into the Leadership Council are several committees on research, continuing care, post-acute care, group practice, the hospital and then a newer committee looking at regional affiliations throughout Montana, Wyoming and the Dakotas.

Several years ago management, along with the board, developed cornerstone principles which state that Billings Clinic is, “at its core, a multispecialty physician group practice, where a community of physicians work in a collegial manner to coordinate health care across a spectrum of services. We are a physician-led organization with a physician CEO, and physicians at all levels of leadership in the organization...” Billings Clinic values partnership among physicians, nurses, clinical and support staff and includes physicians in all levels of decision-making. A not-for-profit community-governed organization, Billings Clinic has an obsessive dedication to patient safety, quality, service and value.

This culture of safety, quality, service and value is enhanced by strong physician leadership. The Billings Clinic board has come to understand that physicians can be high-quality leaders, extremely visionary, and committed to a higher purpose. Physician leadership development has a very high return on investment for Billings Clinic.

Billings Clinic has found success in partnering those physician leaders with hospital managers in dyads. Physician-manager dyads can work very well together and provide great synergy of purpose. Physicians want to be partners with management in delivering excellent, highly reliable, high-quality care. Physicians want to be entrusted and want to trust as well.

Physician leadership has poised Billings Clinic for the future. ACO models are being developed, as well as new payment methodologies, evolving financial incentives, and a more competitive landscape. Billings Clinic is well set to move forward, mostly due to the work done to integrate physicians in management and governance.

The board at Billings Clinic views physicians as a vital part of the organization, to be engaged and considered a partner to move care delivery forward.

East Bay Physicians Medical Group Inc.

Affiliated with Sutter East Bay Medical Foundation

Samuel Santoro, D.O. was named president and chief executive officer of East Bay Physicians Medical Group, Lafayette, Calif., affiliated with Sutter East Bay Medical Foundation, in 2011. As such, Dr. Santoro has helped guide the rapid growth and development of East Bay Physicians Medical Group, a multi-specialty medical group consisting of more than 300 clinicians.

In Dr. Santoro’s experience, physicians, advanced practice clinicians, staff, nurses, and administrators all want to perform excellently, take care of their patients and govern the organization well. The reality though, is that governance has not traditionally been a focus of training for physicians. Understanding the importance of governance education not just as an individual, but as a board is essential.

East Bay Physicians Medical Group is a medical foundation model, part of Sutter Health, the 11th largest not-for-profit integrated health system in the United States, with over 5,000 physicians, about half of which are in independent practice associations, the other half are organized in multispecialty groups. There are 24 affiliated not-for-profit hospitals within the Sutter Health system, with about \$10.5 billion in revenues, and many, many components. East Bay Physicians Medical Group, exclusively contracted with Sutter East Bay Medical Foundation, has nine different outpatient care centers, and supports three major Sutter inpatient facilities covering five campuses. The medical group exists to employ and benefit clinicians.

Product of Board Retreat 2011

Mission

We will strive to be the most high-quality, patient-focused medical group in Northern CA.

5 Pillars of Excellence

We will drive excellence through our pillars of People, Quality, Service, Growth, and Community.

In 2005, the medical group consisted of 43 members, over half of whom were hospitalists. Today, there are more than 300 clinicians. Not all specialties are represented, but there has been tremendous growth. Currently 55 percent of the group is primary care while 45 percent is specialty care.

The board of directors consists of 12 shareholder members with an executive committee and five subcommittees, the most important being quality and peer review. Built out of the quality and peer review committee are credentialing, risk and best practice quality enhancement, pharmacy and therapeutics, electronic health records and the well-being committee.

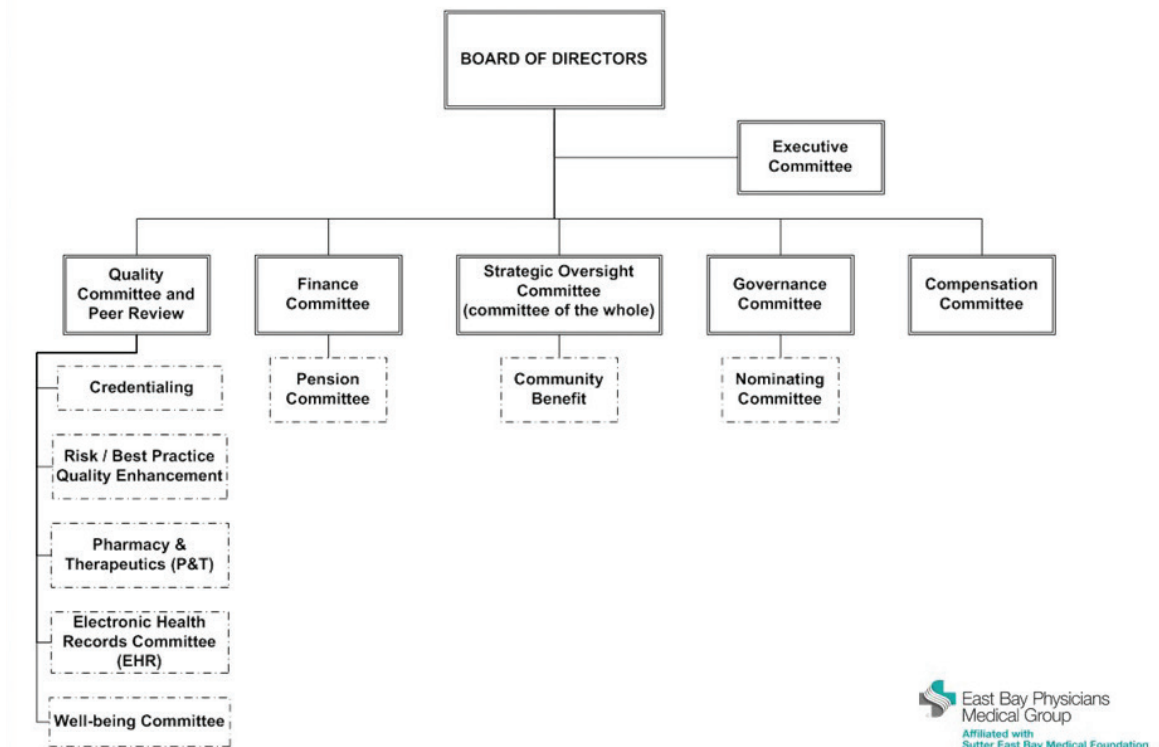
Each of the five subcommittees is chaired by a director of the board. Members of the finance and compensation committees must be shareholders in order to vote. The

governance committee is very important, and a lot of time has been spent on developing and honing the nomination process to ensure a strong pipeline of leaders.

The other committees, such as pension and community benefit, do not require a board member to be the chair, nor do they necessarily require committee members be a shareholder of the group. These committees, then, serve as a training ground for members to better understand the group and potentially, a means of identifying future leaders, particularly for the board of directors.

In 2010, the original East Bay Physicians Medical Group leadership focused on acquiring physician practices which quickly deteriorated as a strategy. The board was forced to take drastic actions including terminating the medical group CEO to stem the tide. This was a

Board Structure



bold step for the board, but not part of a considered plan of action. Fortunately, the board recognized that they needed help and brought in a board consultant who continues to assist. From that point on, the board had focus. The first order of business was to find a president and CEO for the group. The president and CEO is an ex officio voting member of the board, but is not the chair, a key decision.

The second, but equally important, task for the board was to decide what East Bay Physicians Medical Group would be and what they would be about. At this time, the leadership of the medical foundation was in disarray, and distrust was rampant, so the board's focus became the mission, vision and values. Often, organizations have very similar mission, vision and values, so in order to establish a memorable focus, a 'true north' was developed. "Highest quality, patient-focused care, every time" is not only the true north, but also the mission, vision and values and is referenced at every meeting.

In addition to the true north, East Bay Physicians Medical Group's board established five pillars of excellence as well as guiding principles, all very intentionally worded. The pillars of excellence are people, quality, service, growth and community. In the beginning, the organization was so broken, it was determined the primary focus needed to be on people. East Bay Physicians Medical Group is a people organization taking care of people. Rebuilding broken trust was essential.

When the board developed the guiding principles, it determined East Bay Physicians Medical Group would lead and not follow, be owners not renters, have control over their future and have courage to lead change.

In 2012, a strategic roadmap was developed with two major areas of focus, clinical quality and effectiveness, and accountable leadership. A compact was developed by the medical group, which clinicians were asked to sign. Those choosing not to sign are held accountable regardless and can choose to leave the practice should they not wish to. The board also

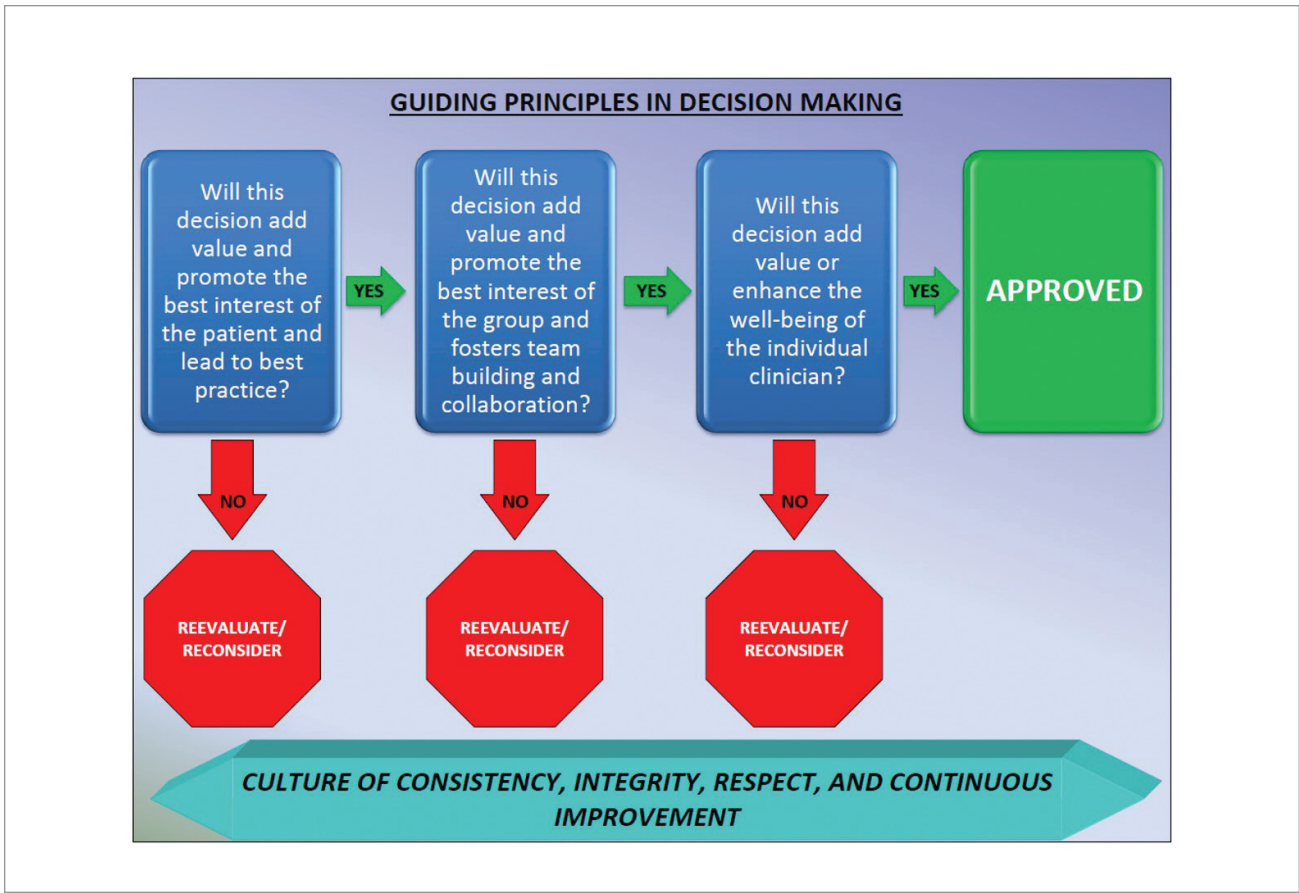
Product of Board Retreat 2011 (continued)

True North

Highest Quality,
Patient-Focused,
Every Time

Guiding Principles

- **Lead not follow**
 - We are owners not renters.
 - Be proactive not reactive.
 - We have control over our own future.
- **Have courage to lead change**
 - Have big, audacious goals.
 - Have pride in what we are about.
- **Ask why**
 - What is the problem we are trying to solve?
 - Is this the question we should be asking from a governance level?
- **Be patient-focused**



developed a board compact which is in every board packet at every meeting. The compact addresses expectations, encourages debate and sharing of opinions and dialogue. However, it is equally important that once the board makes a decision and board members leave the board room, they speak with one voice.

In 2013, the board determined they were still having difficulty with decision-making, so guiding principles were established. These principles were a major turning point for the board and helped set the tone for the culture of the organization. The first and foremost question in the principles is “will the decision add value and promote the best interest of the patients?” If not, the process stops. If yes, the decision will add value to patients, then the next question is “will the decision add value and promote the best interest of the group and foster team building and collaboration?” If no, the process stops. Assuming it gets to that gate, then “will

the decision add value or enhance the well-being of the individual clinician?” If the answer is yes, then it gets approved. The decision-making guiding principles facilitate a culture of consistency, integrity, respect and continuous improvement.

In 2014, board focus shifted to data analytics, culture and relationship building, care coordination, consumer strategy, innovation and strategic growth. Looking ahead, the board is hoping to improve its selection and nomination process, expand the talent pool, develop an in-depth board orientation and succession plan for board members as well as educate shareholders on governance.

East Bay Physicians Medical Group is 100 percent committed to the dream of a high-performing exceptional governance structure. Patients demand it, shareholders demand it, the community deserves it and we believe it is an absolute obligation.

Conclusion

As the field moves toward more integrated and accountable care, more coordination between hospitals and clinicians will be required as well as greater organization of physicians into effective, accountable groups that can manage care across the continuum.

Each of the three organizations highlighted evolved into leading-edge examples of good governance in physician organizations through a long, deliberate process. Each was able to engage physicians and educate them as well as the entire organization about what governance is, its importance and how it should function. The process each organization went through included defining strategy, determining authority and decision-making, evaluating competencies present and missing on the board, director self- and peer-assessment, and establishing compacts.

Organizations and their governance evolve along multiple paths. The pace and degree of evolution may be affected by factors such as organizational ownership, market dynamics, alignment and the need for care redesign and clinical integration. No single path or governance model will work in all organizations and care systems. Providing the highest quality care and a commitment to being the best at delivering it provides a common cause and better alignment for physicians and health care organizations and a roadmap to undertaking the process of identifying the key factors for strong governance in each organization.

Additional Resources

AHA Physician Leadership Forum. All reports can be found at www.ahaphysicianforum.org.

- Blue Ribbon Panel Report: Governance of Physician Organizations (2015)
- AHA/AMA Guiding Principles on Integrated Leadership (2015)
- Innovative Models of Care Delivery (2015)
- Proceedings from the AMA/AHA Joint Leadership Conference on New Models of Care (2014)
- Physician Leadership: The Implications for a Transformed Delivery System (2014)
- Creating the Hospital of the Future: Implications for Hospital-Focused Physician Practice (2012)
- Team-based Health Care Delivery: Lessons from the Field (2012)

AHA Center for Healthcare Governance. All reports can be found at www.americangovernance.com.

- Blue Ribbon Panel Report: Governance of Physician Organizations (2015)
- Trustee Tools for Transformation: Board Readiness Self-Assessment (2013)
- The Value of Governance (2013)
- Governance Practices in an Era of Health Care Transformation (2012)
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