Evolving Independent Medical Group Governance

Six Elements of Effective Medical Group Board Structure
LEGAL CAVEAT
The Advisory Board Company has made efforts to verify the accuracy of the information it provides to members. This report relies on data obtained from many sources, however, and The Advisory Board Company cannot guarantee the accuracy of the information provided or any analysis based thereon. In addition, The Advisory Board Company is not in the business of giving legal, medical, accounting, or other professional advice, and its reports should not be construed as professional advice. In particular, members should not rely on any legal commentary in this report as a basis for action, or assume that any tactics described herein would be permitted by applicable law or appropriate for a given member’s situation. Members are advised to consult with appropriate professionals concerning legal, medical, tax, or accounting issues, before implementing any of these tactics. Neither The Advisory Board Company nor its officers, directors, trustees, employees and agents shall be liable for any errors or omissions in this report, whether caused by The Advisory Board Company or any of its employees or agents, or sources or other third parties, (b) any recommendation or graded ranking by The Advisory Board Company, or (c) failure of member and its employees and agents to abide by the terms set forth herein.

The Advisory Board is a registered trademark of The Advisory Board Company in the United States and other countries. Members are not permitted to use this trademark, or any other Advisory Board trademark, product name, service name, trade name, and logo, without the prior written consent of The Advisory Board Company. All other trademarks, product names, service names, trade names, and logos used within these pages are the property of their respective holders. Use of other company trademarks, product names, service names, trade names and logos or images of the same does not necessarily constitute (a) an endorsement by such company of The Advisory Board Company and its products and services, or (b) an endorsement of the company or its products or services by The Advisory Board Company. The Advisory Board Company is not affiliated with any such company. Advisory Board Company is not affiliated with any such company.

IMPORTANT: Please read the following.
The Advisory Board Company has prepared this report for the exclusive use of its members. Each member acknowledges and agrees that this report and the information contained herein (collectively, the “Report”) are confidential and proprietary to The Advisory Board Company. By accepting delivery of this Report, each member agrees to abide by the terms as stated herein, including the following:

1. The Advisory Board Company owns all right, title and interest in and to this Report. Except as stated herein, no right, license, permission or interest of any kind in this Report is intended to be given, transferred to or acquired by a member. Each member is authorized to use this Report only to the extent expressly authorized herein.
2. Each member shall not sell, license, or republish this Report. Each member shall not disseminate or permit the use of, and shall take reasonable precautions to prevent such dissemination or use of this Report by (a) any of its employees and agents (except as stated below), or (b) any third party.
3. Each member may make this Report available solely to those of its employees and agents who (a) are registered for the workshop or membership program of which this Report is a part, (b) require access to this Report in order to learn from the information described herein, and (c) agree not to disclose this Report to other employees or agents or any third party. Each member shall use, and shall ensure that its employees and agents use, this Report for its internal use only. Each member may make a limited number of copies, solely as adequate for use by its employees and agents in accordance with the terms herein.
4. Each member shall not remove from this Report any confidential markings, copyright notices, and other similar indicia herein.
5. Each member is responsible for any breach of its obligations as stated herein by any of its employees or agents.
6. If a member is unwilling to abide by any of the foregoing obligations, then such member shall promptly return this Report and all copies thereof to The Advisory Board Company.

Project Director
Lea Halim

Design Consultant
Christina Lin

Project Advisor
Anthony D’Eredita

Managing Director
Teresa A. Breen
# Table of Contents

- Related Advisory Board Resources on Governance ........................................... 4
- Advisors to Our Work ......................................................................................... 7
- Executive Summary ........................................................................................... 9
- Section I. Traditional Governance Models Lacking ........................................... 11
- Section II. Six Elements of Effective Medical Group Board Structure ............ 21
  - Element 1: Small elected board ................................................................. 23
  - Element 2: Board membership representative, not constituent ................ 26
  - Element 3: Skilled, group-oriented board members ................................. 32
  - Element 4: Extensive board authority ......................................................... 39
  - Element 5: Effective delegation of board powers .................................... 46
  - Element 6: Disciplined, focused board meetings .................................... 50
- Section III. Implementing Governance Transformation .................................... 55
Available Within Your Physician Practice Roundtable Membership

The Physician Practice Roundtable has developed numerous resources to support medical group leaders in strengthening group culture, leadership, and physician engagement. The most relevant materials are outlined here. All are available in unlimited quantities through your Physician Practice Roundtable membership.

Resources Related to Independent Medical Group Governance

**Research Publications**

**Building a High-Performance Independent Medical Group**

*Organizing Physicians to Deliver Coordinated, Value-Centered Care*

Strategies from successful, highly integrated independent medical groups for encouraging collaboration and coordinating resources to achieve strategic goals.

**Transforming Independent Physician Compensation**

*Transitioning from Individual Collections to a Centrally Determined, Strategically Aligned Compensation Framework*

Key insights and best practices from progressive independent medical groups developing a more centralized and strategically aligned compensation model.

**Ready-to-Use Resources**

**Physician Group Governance Toolkit**

Talking points and diagnostic questions to facilitate board transformation; board member education packet.

**Medical Group Culture Intensive**

Web-based tool to assess medical group culture and identify Advisory Board resources to address gaps.

**Physician Communication Toolkit**

Templates, talking points, and tips for getting important messages to physicians.

**How to Access:**

To order copies of Physician Practice Roundtable publications and to access tools, please visit our website: advisory.com/ppr
Available Beyond Your Membership: Consulting and Management

The Advisory Board Company has many governance-related resources to offer independent physician organizations, in addition to those provided by the Physician Practice Roundtable.

Our Consulting and Management consulting practice offers a variety of engagements to support the development of medical group strategy and optimize financial performance under both traditional and risk-based payment models.

In particular, several groups have taken advantage of Consulting and Management’s Medical Group Governance Engagement. This service, offered by Consulting and Management’s most experienced former physician practice executives, is custom-designed to address the governance needs of independent medical groups.

To find out whether Consulting and Management services may benefit your practice, contact your Dedicated Advisor.

On-the-Ground Consulting Support

Consulting and Management Physician Practice Management Engagements

- **Defining the Model**
  - Medical Group Vision
  - Strategic Imperatives
  - Physician Planning

- **Building the Infrastructure**
  - Revenue Cycle / Coding
  - IT and EMR
  - Financial Operations
  - Governance and Management

- **Optimizing Performance**
  - Physician Engagement
  - Care Coordination
  - Patient Access
  - Satisfaction Surveys and Solutions

Consulting and Management: Service in Brief

- Practice management, interim/long term management, and consulting firm
- 20+ average years of ‘operator’ experience across our consulting team
- Currently serving more than 150 clients in over 40 states
- $8M average financial opportunity found across Consulting and Management medical group assessments

Spotlight: Medical Group Governance Engagement

- Experienced Consulting and Management executive with varied health care industry, legal background
- Specializes in medical group governance
- Leads half-day facilitated discussion with board, leadership team
- Reviews governance structure and org chart; identifies key goals, challenges
- Conducts pre-site planning calls in advance to inform discussion topics
- After session, serves as on-call expert resource for follow-up questions
Available Beyond Your Membership: Talent Development

Many independent medical groups also benefit from services offered by the Advisory Board’s Talent Development division.

Our experienced faculty offer a variety of leadership education modules designed specifically for physicians as well as other health care professionals.

In addition to education, the Talent Development solution set includes 360-degree assessments and follow-up resources for key physician leaders.

To find out whether Talent Development services may benefit your practice, contact your Dedicated Advisor.

### Dedicated Courses Instill Leadership Skill Sets

#### Advisory Board Talent Development Offerings

<table>
<thead>
<tr>
<th>Physician Leadership Development</th>
<th>Foundation Series</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elevate the skills, perspective, and effectiveness of health care leaders</td>
<td>Build management skills across large groups with priority on accessibility and flexibility</td>
</tr>
<tr>
<td>• Highly flexible service structure, designed to meet partner needs</td>
<td>• Series of eight online “badges”</td>
</tr>
<tr>
<td>• Library of 40+ interactive workshops</td>
<td>• Certifications are on Communication, Supervision, Work/Life Balance, and other core management topics</td>
</tr>
<tr>
<td>• Application sessions, tools, support</td>
<td>• Completed at pace of each individual</td>
</tr>
<tr>
<td>• Online learning resources</td>
<td>• Fully virtual but with guided worksheets and assignments</td>
</tr>
<tr>
<td>• Serving nurses, physicians, non-clinicians, C-suite</td>
<td></td>
</tr>
</tbody>
</table>

#### 360 PLUS Leadership Assessment

- **Targeted Competency Model**
  - 15 health care competencies developed in collaboration with health care leaders and 360-degree assessment experts
  - Captures both current performance and future importance data
  - Focus on individual and group development

- **Comprehensive Feedback Approach**
  - Individual reports deliver comprehensive feedback on personal strengths, gaps
  - Feedback is developmental, not evaluative or longitudinal
  - Aggregate reports, benchmarks surface enterprise-wide strengths and weaknesses

- **Faculty-led Development Planning Support**
  - Talent Development faculty guide participants through active reflection, detailed action planning
  - Help align institutional, individual development priorities
  - Workshop includes tools, guidance for leveraging strengths, planning personal development steps
We are grateful to the individuals and organizations that shared their insights, analysis, and time with us. The research team would especially like to recognize the following individuals for being particularly generous with their time and expertise.

**Advisors to Our Work**

**With Sincere Appreciation**

- **Bend Memorial Clinic**
  - Bend, Oregon
  - Greg Hagfors

- **Cardiovascular Institute of the South**
  - Houma, Louisiana
  - David Konur

- **Colorado Springs Health Partners**
  - Colorado Springs, Colorado
  - Debbie Chandler

- **Crystal Run Healthcare**
  - Middletown, New York
  - Gregory Spencer, MD

- **Epstein Becker Green**
  - Washington, DC
  - Paul Gomez
  - Mark Lutes

- **Greensboro Radiology**
  - Greensboro, North Carolina
  - Worth Saunders

- **Hancock, Daniel, Johnson & Nagle**
  - Glen Allen, Virginia
  - Jim Daniel

- **Harbin Clinic**
  - Rome, Georgia
  - Kenneth Davis, MD

- **Husch Blackwell LLP**
  - Kansas City, Missouri
  - Hal Katz

- **InterMed**
  - Portland, Maine
  - Dan McCormack

- **Northside Radiology Associates**
  - Atlanta, Georgia
  - Nancy Holland

- **Pinehurst Surgical Clinic**
  - Pinehurst, North Carolina
  - John Rezen

- **The PolyClinic**
  - Seattle, Washington
  - Lloyd David

- **Proliance Surgeons**
  - Seattle, Washington
  - David Fitzgerald

- **Providence Medical Group**
  - Dayton, Ohio
  - Beth Patak
  - Yvonne Tudor

- **Reliant Medical Group**
  - Worcester, Massachusetts
  - Armin Ernst, MD

- **Spectrum Medical Group**
  - South Portland, Maine
  - David Landry

- **Summit Medical Group, NJ**
  - Berkeley Heights, New Jersey
  - Jeffrey LeBenger, MD

- **Summit Medical Group, TN**
  - Knoxville, Tennessee
  - Tim Young

- **Western Washington Medical Group**
  - Monroe, Washington
  - David Russian, MD
  - Jerry Tillinger
Strong Governance Critical for Independent Medical Group Success.
Independent medical groups are growing larger and facing more complex strategic challenges. As a result, many groups feel the need for greater integration. Strong, efficient governance is critical to making this transformation.

All-Shareholder Boards Undermined by Multiple Flaws.
At many independent groups, all shareholders serve as board members. While this can support physician engagement, it undermines the board’s ability to focus on the long-term needs of the entire group and to make decisions efficiently.

Boards Must Focus on Governance, Not Management.
Governing bodies must set vision, determine strategy and policy, monitor key indicators of the organization’s health, and make major decisions. By contrast, management should focus primarily on day-to-day operations. Boards must focus on governance and avoid intervening closely in management; otherwise pressing management concerns are likely to distract from critical governance work.

Small Board Size Needed to Govern Efficiently.
Having a small board reduces the practical challenges of running a board, ensures effective and thorough discussion, and facilitates decision making. Effective boards commonly have fewer than 10 members.

Representative, Not Constituency-Based, Board Composition Ensures Focus on Group-Level Strategy.
While members of constituency-based boards are elected by and accountable to individual specialties, care sites, regions, or other interest groups, all seats on a representative board are elected at-large. This ensures board member focus on the needs of the group as a whole.

Elevating Board Skill Set Requires New Processes, Investment in Education and Skills Training.
Medical groups should develop a well-defined list of needed board member characteristics and hardwire processes that ensure careful selection of board members. They should also invest in continually educating board members in industry trends as well as leadership skills, and in adequately compensating board members for their service.

Boards Need Complete Authority Over Key Decisions Affecting Group Strategy—including Physician Compensation.
At many independent medical groups, shareholders have significant decision-making powers superseding those of the board. While in some areas this is sustainable, shareholder control over physician termination, acquisition or divestiture, and physician compensation can undermine the board’s ability to set and execute on strategy.

Separate Board Chair and CEO Roles, Along with Robust Committee Structure, Enable Boards to Focus on Governance.
To prioritize their time for governance rather than management concerns, boards must delegate powers relating to management. Dedicated, separate oversight of the governance and management functions, as well as strong physician leadership outside the board, support this goal.

Strong Meeting Discipline Essential to Board Effectiveness.
Unfocused board discussions waste time that needs to be prioritized for pressing governance issues and the engagement of valuable board members. To avoid this, high-performing boards focus on constantly improving meeting discipline.

Governance Transformation Requires Sustained Effort, Compromise.
Medical group leaders seeking to transform board structure must move through a process of securing physician support, educating and readying board member talent, and establishing a new leadership culture across the organization.
Section I

Traditional Governance Models Lacking
Consolidation in the provider market is proceeding at a rapid pace. Driven by declining reimbursement, growing regulatory complexity and uncertainty, and the demands of new value-based payment contracts, increasing numbers of physicians are seeking out opportunities to practice in a large-group setting, whether hospital-affiliated or independent.

A 2013 *Health Affairs* study of over 500,000 physicians submitting Medicare claims showed a notable increase in the proportion of physicians practicing in groups of 50 or more physicians. While this study did not distinguish between hospital-employed and independent settings, reports commissioned by the American Medical Association suggests that this trend holds specifically for physicians in independent practice as well.

Many independent medical groups are growing larger, and this trend is likely to accelerate as younger physicians—known to be less inclined to go into independent solo practice—graduate from training.

**Physicians Practicing in Groups of Over 50 Providers**
Health Affairs study of over 500,000 physicians submitting Medicare claims

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>30.9%</td>
</tr>
<tr>
<td>2011</td>
<td>35.6%</td>
</tr>
</tbody>
</table>

**Independent Physicians Practicing in Groups of Over 50 Providers**
Comparison of two American Medical Association studies of over 3,000 physicians

<table>
<thead>
<tr>
<th>Year</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>4.6%</td>
</tr>
<tr>
<td>2012</td>
<td>6.5%</td>
</tr>
</tbody>
</table>

As independent medical groups are getting bigger, they are also facing new types of challenges.

Risk-based payment models are now available in many markets. Medical groups of all types—primary care, specialist, and multispecialty—must find ways to secure these new contracts, develop the infrastructure needed to execute on them, and elevate patient engagement in order to effectively manage population health.

Provider competition, too, is increasing and becoming more complex. Medical groups are competing over inclusion in newly emerging narrow insurer networks. As physician employment by hospitals grows, independent medical groups are also assessing new partnerships and referral relationships.

Finally, with the growth in high-deductible health plans, medical groups are challenged to compete for patients based on superior access, service, and care quality.

### Market Changes Creating New Priorities for Medical Groups

#### Mastering Risk-Based Payment Models
- Understanding payer strategy, needs
- Building infrastructure for population health management
- Redesigning physician compensation incentives to support new care goals
- Elevating patient engagement to improve care outcomes

#### Navigating the New Competitive Landscape
- Securing inclusion in newly forming narrow networks
- Assessing Clinical Integration contracting, other provider partnerships
- Navigating new referral relationships as hospitals employ more physicians
- Staying ahead of new types of competitors (e.g., retail clinics, telehealth providers)

#### Preparing for the Consumer-Patient
- Improving patient access, scheduling convenience
- Enhancing patient experience, monitoring patient feedback
- Bolstering point-of-service collections
- Preparing providers to help patients navigate cost, answer cost questions related to referrals

Source: The Advisory Board Company interviews and analysis.
Taken together, larger size and rapidly evolving strategy create the need for independent medical groups to move toward a more cohesive culture.

Historically, many independent medical groups have pursued only a limited degree of integration. There may be some centralized services offered, but physicians and practice sites continue to function autonomously.

But many independent groups today see the need to operate and invest in a more integrated and coordinated fashion. This requires a different paradigm, based on the view that individual physician success is the result of group-wide wide success.

A critical factor leading to this cultural transition is the fact that other stakeholders in the health care market—most notably, hospitals that employ physicians—are becoming more consolidated and using organization-level strategy and resources to compete with independent medical groups. Independent medical groups that continue to operate as collections of autonomous practices, rather than integrated organizations, will struggle to compete.

Key to accomplishing this paradigm shift is effective group governance.

### Need for Change in Group Culture, Self-Perception

**Traditional Independent Medical Group**

*Preserving physician autonomy*

- Physicians focused on maximizing personal productivity, income
- Group provides minimal centralized services needed

**Integrated Independent Medical Group**

*Investing and acting as a group*

- Physicians have shared incentive to focus on group-wide care delivery improvements, care coordination
- Group makes significant investments in infrastructure, coordinates change across practices

### Can't Lag Behind the Competition

“With so much consolidation in the market, our relationships are now with large organizations, not local practices. That means we too have to function as an organization. Physicians have to think about what the entire group needs, five and ten years from now, and not just what benefits their practice.”

David Fitzgerald, CEO
Proliance Surgeons

Source: The Advisory Board Company interviews and analysis.
Many independent medical groups were founded, or came together, with just a small number of highly involved physicians. These groups tended to organize themselves in ways that gave all physicians a voice in running the group, usually creating a governance board that included all shareholders as directors.

The all-shareholder governance model is still common even among well-established groups that have grown larger over the years. In a 2014 Physician Practice Roundtable survey of large independent physician organizations, almost a third of respondents—including specialist, primary care, and multispecialty medical groups—reported having this type of governance model.

There are good reasons why some groups continue to use this model. Having a seat at the board helps mitigate physician concerns over losing their practice autonomy to the larger group and appeals to physicians’ collegiality. It also ensures shareholder support and commitment to the execution of board decisions.

<table>
<thead>
<tr>
<th>Reasons for All-Shareholder Governance Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Natural structure for smaller medical groups</td>
</tr>
<tr>
<td>• Mitigates physician concerns over entering group practice environment; may ensure higher level of practice autonomy</td>
</tr>
<tr>
<td>• Appeals to physicians’ sense of collegiality</td>
</tr>
<tr>
<td>• Creates opportunity for all shareholders to be engaged in, contribute to group decisions</td>
</tr>
<tr>
<td>• Ensures shareholder support for group decisions</td>
</tr>
<tr>
<td>• Reduces chance of conflict, lawsuits among shareholders in case of poor board decisions</td>
</tr>
</tbody>
</table>

1) Includes both single-specialty and multispecialty.
But Significant Drawbacks to Having All Shareholders at the Table

While there are good reasons for an all-shareholder board, a closer look reveals significant challenges posed by this model.

The first and most important is the fact that it undermines the board’s ability to focus on the long-term, organization-level needs of the entire group. When each shareholder is granted a board seat, a clear message is sent that the purpose of a board seat is to represent oneself. In that culture, when the interests of the greater group and an individual board member conflict—as they often do when a proposal with long-term benefits requires immediate investments that hurt individual physician bottom lines—shareholder board members will likely vote with their individual practice in mind.

There are also significant practical challenges. Large boards cannot make decisions efficiently; educating board members about relevant issues takes disproportionate time and energy from the CEO; and very limited board turnover means it is harder for the board to change course.

Finally, the fact that at least some members of an all-shareholder board are likely to be disengaged (e.g., regularly missing board meetings) can make governance itself seem an unimportant function in the group.

Five Key Challenges of an All-Shareholder Board

- **Lack of Focus on Long-Term, Group-Level Needs**
  - Shareholder board members perceive board seats as opportunity to represent oneself rather than larger medical group
  - Individual shareholder board members may prioritize short-term benefit to long-term plans that may impact the group after the individual has left the organization

- **Inefficient Board Meetings, Decision-Making Process**
  - Larger boards face significant difficulties in managing discussion at board meetings
  - Larger boards are often unable to make decisions in a limited time frame

- **Excessive Effort Needed to Educate Board**
  - Difficult, if not impossible, for all shareholder board members to become fully educated, engaged on strategic issues
  - Educating all shareholder board members requires significant outlay of time, effort

- **Limited Board Ability to Change Course**
  - Shareholder board members cannot be replaced as a consequence of poor decisions or failure to execute duties (e.g., prepare for meetings)
  - Lack of turnover limits board’s ability to consider new ideas, change course in response to market evolution

- **Reduced Cultural Value of Governance**
  - Not all shareholder board members have strong interest in governance, board service
  - Shareholders who serve on board but do not prioritize attending, preparing for board meetings send cultural message devaluing role of governance

Source: The Advisory Board Company interviews and analysis.
In light of the challenges outlined on the previous page, many independent medical groups with an all-shareholder board leverage an executive committee (EC) as a governing body. Most groups already have an EC—usually composed of high-level administrative executives like the CEO and CFO, along with several physician leaders—that oversees the management of the group. Such an EC is generally empowered to make many decisions for the group. Transforming it into a governing body can be seen as a matter of expanding those delegated powers and designating EC members as fiduciaries for the group. This results in a small, educated governing body that is explicitly selected to protect the interests of the group.

However, this is not a seamless solution. By design, ECs often have multiple standing members serving for long periods (such as the CEO, CMO, etc.), which limits turnover. As a result, fewer physician shareholders are able to participate in governance. There is also often confusion about what an EC can decide and what requires board approval, since an EC by definition is a committee of the board. In addition, as long as all shareholders serve on the board, they are still all fiduciaries to the organization.

Some Groups Expand Executive Committee Powers to Function Nearly as Board

### All-Shareholder Board
- Includes all shareholders
- Organization’s legal board
- Usually meets quarterly

### Executive Committee
- Includes CEO, other executives; may include physician leaders
- May be elected or appointed
- Meets frequently

#### Delegated Powers
**At Most Groups**
- Implementation of strategic plan, board decisions
- Minimal above-budget expenditures
- Day-to-day management of group

**At Some Groups**
- Strategic plan approval
- Major decisions
- Budget approval
- Wide range of expenditures
- Explicit fiduciary duty

### Key Advantages of Governance by EC
1. Executive committee smaller, more efficient than all-shareholder board
2. Committee members committed, educated on key issues
3. Committee members selected to protect group interests rather than their own; may be designated fiduciaries

### Potential Drawbacks of Governance by EC
- Executive committee may have multiple standing members, low turnover; as a result, few physicians engaged in governance
- Board, EC respective powers may not be clear
- Shareholders still legal fiduciaries; responsible for staying fully informed about all executive committee actions, observing confidentiality

---

1. Executive committee.
2. To one another, since all are board members.

Source: The Advisory Board Company interviews and analysis.
Some of the drawbacks of having an executive committee serve as the governing body—confusion over authority, limited physician engagement—can be addressed through careful design of the model.

One example of how to do this comes from Crystal Run Healthcare, a large and independent medical group based in Middletown, New York, that has been successfully governed by an executive committee since its founding in 1996. There are three key reasons why Crystal Run has thrived under an EC governance model.

First, the group’s governing documents clearly spell out which powers belong to physician partners and which to the EC. The documents also delegate enough powers to the EC so that its members can be considered fiduciaries for legal purposes. This prevents role confusion.

Second, the executive committee includes a large number of physician leaders from across the group.

And third, the EC is committed to educating physician partners and keeping them engaged. Combined with a unique group culture—one characterized by a high level of trust in the leadership—this serves to lessen concerns about the level of physician engagement in group governance.

**How Crystal Run Healthcare Makes Governance by Executive Committee Work**

- **Governing Documents Clearly Delegate Fiduciary Powers to EC**
  - Partnership agreement explicitly authorizes EC to make majority of decisions without partnership vote, designates EC members fiduciaries
  - Partnership vote required on admission of new partners, expenditures above $1M

- **Comprehensive Physician Representation on EC**
  - Seven of ten EC members are physicians elected by partnership to represent specialty divisions
  - Physician CEO, CMO, COO are standing members

- **Extensive Education, Outreach from EC to Physician Partners**
  - EC members invest significant time, effort in communicating with other physicians in the group
  - Multiple channels used for communication, including one-on-one partner meetings

**Case in Brief: Crystal Run Healthcare**

- 300-provider, 110-partner independent medical group based in Middletown, NY
- Highly successful, growing rapidly, pursuing ambitious value-based contracting strategy—including launch of own health plan
- Strong executive committee authorized to make most group-level decisions
- Entire partnership required to vote on certain high-cost, high-risk decisions

**Building on a Unique Group Culture**

“...The partnership really does trust and defer to the executive leadership on many things. It’s about our culture and the management style. Our founder and CEO is very knowledgeable and a charismatic guy; he gets people fired up about things. If there was a different management style, we may have felt the need for a different governance structure.”

Gregory Spencer, MD, CMO
Crystal Run Healthcare

Source: The Advisory Board Company interviews and analysis.
While placing the executive committee in a governing role may be workable for some groups, it is likely to conflate governance and management. To govern an organization is to take responsibility for its overall well-being and direction. Effective governing bodies engage in high-level thinking to set vision; determine the strategy, policies, and culture that bring that vision to life; and monitor key indicators of the organization’s health. They also make major decisions. By contrast, management is focused primarily (though not exclusively) on day-to-day operations and execution of directional guidance given by the governing body.

To remain distinct, these functions should be performed by different bodies—the board and management team, respectively. Failure to separate them generally leads to management concerns, which tend to be more timely and pressing, overtaking those of governance. This inhibits a medical group’s ability to evaluate and chart its course at a high level.

Since ECs are generally composed of leaders with management responsibilities, they are likely to conflate governance and management duties.

### Executive Committee Governance Model Conflates the Two

#### Governance Duties
*Focused on Vision and Oversight*

- Vision, strategy development
- Policies and procedures
- Approval of capital and operating budgets
- Financial performance oversight
- Clinical, operational performance oversight
- Hiring, monitoring CEO
- Regulatory compliance
- Approval of outside investments
- Major decisions (e.g., M&A, affiliations)
- Self-monitoring of governing body

#### Management Duties
*Focused on Execution*

- Strategic plan and initiative development
- Implementation of strategic plan and initiatives
- Development of capital, operating budgets
- Business plan implementation (including all aspects of clinic operations)
- Financial management
- Physician and staff engagement
- Succession planning
- Leadership development

#### Key Areas of Focus

- Debate, deliberate
- Make high-level decisions
- Review, approve proposals
- Raise concerns, questions

#### Person or Body Responsible

**Board**

**CEO, committees, management team**

Executive committees serving as governing bodies are responsible for both sets of tasks; likely to conflate the two, allow day-to-day management concerns to take precedence.

Source: The Advisory Board Company interviews and analysis.
The discussion on the previous several pages suggests that effective independent medical group board must be guided by three key guiding principles.

First, the board must be dedicated to the organization’s long-term interests. Second, the board must also be effective at executing its role—educated and trained, and not stymied by too large a size. And finally, the board must also be focused on governance, not management.

The rest of this publication will lay out more specific elements of an effective medical group board structure that follows these three guiding principles.

Guiding Principles for a More Effective Independent Medical Group Board

- Board members fulfill fiduciary duty
- Board looks out for interests of whole group
- Board focused on developing strategy for long-term endeavors (e.g., care delivery transformation, new payer partnerships)

Dedicated to Long-Term, Organization-Level Interest

- Board members have thorough understanding of organizational finances, market position, industry changes
- Board able to make decisions at a pace that matches market developments
- Board decisions binding on group

Focused on Governance

- Board dedicates its time to governance, not management
- Board effectively delegates management operational duties to committees, CEO, and management team

Effective at Executing Role

- Board members fulfill fiduciary duty
- Board looks out for interests of whole group
- Board focused on developing strategy for long-term endeavors (e.g., care delivery transformation, new payer partnerships)

1) Performing due diligence (e.g., seeking full information about relevant issues, attending meetings), observe confidentiality, abstain from voting when there is conflict of interest.

Source: The Advisory Board Company interviews and analysis.
Six Elements of Effective Medical Group Board Structure

- Element 1: Small elected board
- Element 2: Board membership representative, not constituent
- Element 3: Skilled, group-oriented board members
- Element 4: Extensive board authority
- Element 5: Effective delegation of board powers
- Element 6: Disciplined, focused board meetings
In the following pages we describe six key elements of an effective medical group board structure.

These elements fall into two categories. The first three focus on the makeup of the board—its size, composition, and the characteristics of its members. The following three concern the role of the board in the larger medical group organization—the extent of the board’s authority, how it delegates, and how it structures its meetings.

It is important to note that state law, tax status, and other individual factors will affect the considerations of each independent medical group in designing its board structure. Nevertheless, most large independent medical groups should find the guidance in the following pages to be broadly applicable.

Six Elements of Effective Medical Group Board Structure

<table>
<thead>
<tr>
<th>Defining Board Membership</th>
<th>Scoping Board Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Small elected board</td>
<td>4 Extensive board authority</td>
</tr>
<tr>
<td>2 Board membership representative, not constituent</td>
<td>5 Effective delegation of board powers</td>
</tr>
<tr>
<td>3 Skilled, group-oriented board members</td>
<td>6 Disciplined, focused board meetings</td>
</tr>
</tbody>
</table>

Source: The Advisory Board Company interviews and analysis.
Element 1: Small elected board

Independent Medical Groups Tending Toward Smaller Board Size

The first element of an effective medical group board is that it is small – small enough for board members to be able to engage in productive dialogue and keep their purview and focus on governance and strategy.

Many large independent medical groups are already moving toward smaller governing boards. In a 2014 Physician Practice Roundtable survey of large independent physician organizations, 70% of respondents stated they were governed by a subset of physicians, rather than the entire shareholdership. Of those, the vast majority, which includes several groups of over a hundred shareholders, have boards of only five to nine members.

This trend also holds outside the health care industry. A survey of over a thousand public companies revealed an average board size of eight to nine members, and a mode (most frequently reported size) of just seven.

---

1) Includes both single-specialty and multispecialty independent medical groups.
2) In groups that do not have all shareholders on the board.

---

There are several substantial advantages to smaller governing boards. Small size reduces the practical challenges of running a board, from planning meetings that everyone can attend to ensuring that all members are educated about the issues facing the organization. It is easier for a smaller group to have an effective discussion, with minimal time constraints on debate and a real opportunity for each board member to contribute and make a difference. And when the time comes to make a decision, it is much more realistic for a small group to reach consensus.

Indeed, there may now be hard evidence that smaller boards perform better. A recent study of 400 publicly traded companies commissioned by the Wall Street Journal suggested that those with smaller boards—averaging 9.5 members—consistently return higher dividends to their shareholders than those with larger boards.

Organizations looking to adopt a smaller board should be aware of a few drawbacks, including the greater fiduciary burden and risk of legal exposure for each board member and the fact that a smaller size may limit the number of represented physician perspectives.

**Key Advantages of Small Boards**

- **Streamlined Logistics**
  - Board meetings easier to schedule, facilitate
  - CEO, other senior leaders can educate all board members in full detail on any relevant issues prior to meeting

- **Effective Discussion**
  - Detailed discussion, debate can take place in reasonable amount of time
  - Higher board member engagement, sense of individual responsibility to the broader organization

- **Efficient Decision Making**
  - Less potential for needless amendments, confusion over smaller details
  - Easier to reach majority consensus
  - Closer supervision of CEO

**2011-2014 Public Company Shareholder Returns Relative to Peer Average**

<table>
<thead>
<tr>
<th>Average Board Size 14 Members</th>
<th>Average Board Size 9.5 Members</th>
</tr>
</thead>
<tbody>
<tr>
<td>8.5%</td>
<td>(10.9%)</td>
</tr>
</tbody>
</table>

400 public companies

**Drawbacks to Consider**

- Greater fiduciary burden, risk of legal exposure for each individual board member
- Possibility of “groupthink”—excessive intellectual cohesion, uniformity among board members
- Limited number of seats to represent key medical group perspectives

1) Small boards found to dismiss CEOs more frequently for poor performance.
What is the best way to elect a small board? There are four dimensions to designing an effective election process.

First, groups must determine the role of a nominating committee. High-performing organizations tend to leverage nominating committees to pre-screen candidates—including incumbents—to ensure that those running for the board would meet its current needs. This is discussed in more detail on pages 33 and 34.

Second, groups must choose between letting individuals compete for seats in an election and presenting a slate of preselected candidates for an up-or-down vote. This choice depends on whether the group’s chief concern is elevating board talent or increasing turnover and trust in the board.

Third, the latter concern may sometimes suggest a need for term limits. However, term limits can disrupt the board’s work (e.g., if a critical member terms out in the middle of an initiative) and limit board member engagement. A nomination process that gives due consideration to the need for fresh perspectives can eliminate the need for term limits.

Finally, when it comes to term length and structure, most groups opt for two- or three-year staggered terms.

### Four Dimensions to Designing an Effective Election Process

<table>
<thead>
<tr>
<th>Nominating Committee Role</th>
<th>Election Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Nominating committee can select, pre-approve candidates to ensure board talent quality</td>
<td>• Shareholders can vote up-or-down on entire slate of candidates (allows nominating committee to preselect next board based on known needs)</td>
</tr>
<tr>
<td>• Nominating committee should evaluate incumbents as well as new candidates before they can run</td>
<td>• Alternatively, shareholders can select among multiple candidates for each seat (increases competition, turnover)</td>
</tr>
<tr>
<td>• Alternatively, committee can simply identify, encourage candidates to increase competition, turnover</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Presence of Term Limits</th>
<th>Term Length, Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Establishing term limits can increase board turnover</td>
<td>• Term length usually set at two or three years</td>
</tr>
<tr>
<td>• However, term limits can disrupt critical board activities, needlessly shorten service by talented members, decrease member engagement</td>
<td>• Board terms should be staggered to ensure continuity throughout election cycles</td>
</tr>
</tbody>
</table>

Effective nomination process can eliminate perceived need for term limits

Source: The Advisory Board Company interviews and analysis.
While small size is critical to the board’s efficiency, the second element—representative rather than constituent composition—ensures its focus on the needs of the larger medical group as a whole.

Most medical groups are composed of multiple provider constituencies with different interests and perspectives. These differences tend to be larger in multispecialty groups, but are also present when physicians in the same specialty are distinguished by factors such as geography or former affiliation.

To govern effectively, a board should incorporate a variety of constituency perspectives. However, there is a fundamental difference between a constituency-based board, composed of members elected by each of the individual constituencies, and a representative board, whose members are elected by the larger medical group as a whole. In the latter, board members have a mandate to represent the larger organization even while they bring constituency-specific views.

While constituency-based boards are very common, they present several problems. Most critically, these board members are chiefly accountable to their constituencies and most focused on their needs, rather than those of the larger organization as a whole.

Core Differences Between Constituent, Representative Board Composition

<table>
<thead>
<tr>
<th>Constituency-Based Board Example</th>
<th>Representative Board Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty Division (Cardiology)</td>
<td>Entire Group</td>
</tr>
<tr>
<td>Elects representative who understands specialty needs</td>
<td>Elects representative who understands group needs</td>
</tr>
<tr>
<td>Cardiologist Board Member</td>
<td>Cardiologist Board Member</td>
</tr>
<tr>
<td><strong>Mandate</strong>: Advocate for cardiology interests</td>
<td><strong>Mandate</strong>: Provide specialty perspective</td>
</tr>
<tr>
<td>Board member selected from smaller talent pool, accountable to division rather than organization</td>
<td></td>
</tr>
</tbody>
</table>

Source: The Advisory Board Company interviews and analysis.
The case study on this page offers an example of the way in which a constituency-based board can undermine organization-level interests. Pseudonymed Vita Medical Group has a board composed of representatives from its primary care, medical, and surgical divisions, as well as a community member. The group has a large risk-based payment portfolio and has been working to reduce utilization of high-end specialty care.

Recently, the CEO proposed to the board that the group divest two spine surgery practices. The PCPs, medical specialists, and a community member on the board supported the proposal, which made clear business sense for the group’s changed economics. However, the proposal did not garner supermajority support because representatives of the surgical division—which would be negatively impacted by the divestiture—naturally opposed it.

This incident highlights two problems with a constituency-based board. First, its members cannot typically be expected to place the organization above their own specialty interest. Second, the balance of perspectives (and skill sets) on the board may not be aligned with the group’s current strategic needs.

**Specialty Representation on Board Undermines “No-Brainer” Business Decision**

**Board Facing Conflict Between Specialty and Group-Level Interests**

- Medical group has taken on large risk-based payment portfolio
- Spine surgery projected to lose volumes, generate net losses due to improved care management
- CEO recommends divestiture of two spine surgery practices

**Vita Medical Group Board**

- PCPs, Medical Specialists, Community Member
  - Unanimously support divestiture as “no-brainer” business move
- Surgical Division Representatives
  - Represent division affected by potential divestiture; oppose proposal

Divestment proposal fails to garner board supermajority

**Case in Brief: Vita Medical Group**

- 200-physician independent medical group based in the South
- Governance board includes six physicians elected to represent specialty divisions and one community member
- Board supermajority vote required for major decisions, including clinical service divestment

---

1) Pseudonym. Source: The Advisory Board Company interviews and analysis.
In light of the considerations raised on the previous two pages, it is clear that, ideally, all members of an effective medical group board should be elected at large—by the entire group, rather than individual constituencies.

However, many groups still feel the need for a venue in which specific constituencies (whether based on specialty, geography, or other factors) can voice their needs and concerns.

Summit Medical Group, a large independent multispecialty physician organization in New Jersey, has addressed this need by creating another physician leadership body, the Clinical Council, underneath the board. This council is populated by specialty leaders, whose role is to weigh in on clinical policies and initiatives and make recommendations to the board. It is effectively a clinical operating committee of the board, designed to give specialty leaders direct access to the board and executive leadership as well as the opportunity to interact with one another.

**Forgoing Constituency-Based Representation at the Board Level**

Instead, Specialty Needs Represented via Clinical Council

<table>
<thead>
<tr>
<th>At-Large Seats</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board members selected for ability to pursue interest of entire group, elected by entire group</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Group Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 members</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>“30,000-foot level”</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Fiduciary for group</td>
</tr>
<tr>
<td>• Sets strategic direction</td>
</tr>
<tr>
<td>• Makes major decisions</td>
</tr>
<tr>
<td>• Develops policies</td>
</tr>
<tr>
<td>• Decisions binding on group, CEO, all committees</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Seats Reserved for Specialty Department Chairs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Members expected to represent specialty interests, selected by specialty departments</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical Council</th>
</tr>
</thead>
<tbody>
<tr>
<td>4 service line directors, 7 department heads, management group; chaired by CMO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>“15,000-foot level”</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reviews clinical policies, initiatives affecting service lines</td>
</tr>
<tr>
<td>• Makes recommendations to board</td>
</tr>
<tr>
<td>• Provides venue for service lines to share concerns, advocate for specialty interests</td>
</tr>
</tbody>
</table>

**Case in Brief: Summit Medical Group, NJ**

• 400-physician, 130-shareholder independent medical group based in Berkeley Heights, New Jersey
• All board seats elected at-large to ensure board members represent group, not constituency, interests
• Specialty divisions represented at operational Clinical Council that reports up to the board

Source: The Advisory Board Company interviews and analysis.
Colorado Springs Health Partners (CSHP), an independent multispecialty group, uses a different approach to ensure that individual constituencies have a voice in the organization’s governance.

All of CSHP’s board members are elected at large, with all shareholders voting for all board seats regardless of specialty. However, at the end of each election cycle the board identifies a particular specialty that both lacks current board representation and is one that the board wishes to have regular input from, whether due to its constituency size or other explicit concerns. The members of this specialty then elect a representative to occupy a special, additional non-voting board seat.

In this way, the minority specialty is able to participate in board discussion and influence decision making, without compromising the organization’s principle that final decisions should be made by individuals elected by shareholders to represent the group (rather than a particular constituency).

**Case in Brief: Colorado Springs Health Partners**

- 77-shareholder independent multispecialty medical group based in Colorado Springs, Colorado
- Governed by nine-member board, elected at-large
- Use additional non-voting board seat for minority specialty input deemed by the board as necessary

**Source:** The Advisory Board Company interviews and analysis.
External board members

Including an Outside Perspective

Seeking to create a truly objective board, focused on the future of the entire organization rather than the stymied by individual physician concerns, some medical groups recruit outside board members. Bend Memorial Clinic in Oregon has two external members on a board of nine. These individuals—currently, owners of a large local business and a private equity group—bring non-clinical skills and perspectives rarely found among physicians and have extensive experience in governing other organizations in the community. They also help ensure a mission-centered, high-level tone to board discussions.

Note that Bend’s external board members have a full vote. While this may be controversial for some medical groups, the vote is a key sign that external board members can have a real impact on the board’s decisions. Denying a full vote to external board members is likely to reduce their engagement and interest in participating, and prevent them from making the full contribution of which they are capable.

Bend Memorial Clinic Has Two Voting Non-Physician Board Members

Medical Group Board
Nine Voting Members

- Seven physician board members
- Two outside board members:
  - Owner of large local business
  - Private equity group owner

Benefits of External Board Members
- Provide relevant non-clinical expertise (e.g., finance, IT)
- May have previous experience, skill in board governance
- Can offer a patient perspective
- Question physician-centric outlook
- Steer board discussion away from physician self-interest, operational details unfamiliar to external board members

Case in Brief: Bend Memorial Clinic
- 65-shareholder independent medical group, based in Bend, Oregon
- Governed by nine-member elected board that includes two voting community members

Critical Reasons to Grant Vote to External Board Members
- Communicates respect for external board members as equals
- Ensures external board member engagement, motivation to make positive impact

Source: The Advisory Board Company interviews and analysis.

©2015 The Advisory Board Company • 31182
Addressing Likely Shareholder Objections to External Board Member Voting

It is easy to understand why shareholders might oppose the presence of voting external members on the board. Two common objections are listed here in the left-hand column. First, shareholders may feel that external board members do not have the same financial “skin in the game” as physicians and therefore should not have the same decision-making power. Second, they may be concerned that the CEO or other senior leaders, who are likely to be the ones who identify and recruit these board members, would use this as an opportunity to bias the board in favor of initiatives that physicians might oppose.

Bend Memorial Clinic has addressed the first of these concerns by requiring that the majority of the board, as well as its chair, must be physicians. This prevents external board members from wielding substantial voting power or influence on the board.

As for the second objection: Bend’s shareholders elect external board members in the same way as physician board members. The nominating committee ensures that there is more than one candidate for each external (as well as each physician) seat.

<table>
<thead>
<tr>
<th>Common Objections to External Board Member Voting</th>
<th>Bend Memorial Clinic’s Solutions to Common Objections</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>No Personal Exposure to Vote Outcomes</strong></td>
<td><strong>Limiting External Board Member Number, Influence to Reduce Impact of Votes</strong></td>
</tr>
<tr>
<td>- External board members, unlike physician shareholders, not financially affected by medical group’s success or failure</td>
<td>- Majority of board members must be physicians</td>
</tr>
<tr>
<td><strong>May Undermine Shareholder Control</strong></td>
<td>- Board chair must be a physician</td>
</tr>
<tr>
<td>- External board members often identified by senior leadership, rather than shareholders</td>
<td></td>
</tr>
<tr>
<td>- If external members have a vote, senior leaders could “stack” board in favor of proposals that shareholders may not support</td>
<td></td>
</tr>
</tbody>
</table>

### Sample Board Election Ballot

<table>
<thead>
<tr>
<th>Seat 1</th>
<th>Seat 2</th>
<th>Seat 3 (External)</th>
</tr>
</thead>
<tbody>
<tr>
<td>❑ Dr. Black</td>
<td>❑ Dr. Brown</td>
<td>❑ Al Smith</td>
</tr>
<tr>
<td>❑ Dr. White</td>
<td>❑ Dr. Gray</td>
<td>❑ Sue Jones</td>
</tr>
</tbody>
</table>

Source: The Advisory Board Company interviews and analysis.
Element 3: Skilled, group-oriented board members

Building a Board That’s Fit to Govern

After creating a board that is adequately sized and group-oriented, the next priority is to ensure that board members are fully prepared to execute their role.

This is an area of significant concern among large independent medical groups. In responding to our 2014 survey on governance, over 40% of independent group leaders disagreed with the statement that board members in their group possessed the skills and knowledge necessary to govern in today’s rapidly changing health care market. Of multiple potential governance issues raised in the survey, this one elicited the most dissatisfaction with the status quo.

To elevate the quality of talent serving on their boards, medical groups should take three important steps. First, they must hardwire processes that ensure careful selection of board members. Second, they should invest in continual education of board members. And third, they should offer appropriate compensation for board service in order to elevate its status in the organization and lower barriers to entry for high-performing, talented physicians who may be concerned about losing clinical time.

Many Medical Groups Concerned About Board Member Skill Level

Group Leaders Believing That Board Members Possess Knowledge, Skills Needed to Govern in Today’s Health Care Market

N = 31 large independent physician organizations

42% Say No

Three Steps to Elevate Board Member Quality

Careful Selection
- Clear vision of criteria for board members
- Effective board member nomination process

Continual Education
- Leadership training, relevant education for board members

Appropriate Rewards
- Appropriate compensation to board members for board service


1) “Yes” encompasses survey respondents marking that they “strongly agree,” “agree,” or “tend to agree” with the statement “Board members possess the skills and knowledge needed to govern a health care business in today’s rapidly transforming industry.” “No” encompasses those marking that they “strongly disagree,” “disagree,” or “tend to disagree” with the same statement.
To select board members wisely, most well-governed groups leverage a nominating committee to identify, encourage, and in some cases pre-approve potential board members.

The nominating committee should be an objective and capable body with an understanding of the diverse perspectives present in the group as well as the needs of the board.

The PolyClinic, a large multispecialty group based in Seattle, assembles its nominating committee through a selection process designed to prevent incumbent bias and include key specialty perspectives. Each of the group’s four specialty divisions submits two candidate names to the board chair. Along with the CEO and CMO, the chair selects one of them to serve on the nominating committee. The chair, CEO, and CMO also choose another physician from among the group as a whole. This process gives specialty divisions an opportunity to influence the nominating committee membership, though not to determine it fully. No current board members serve on the nominating committee.

The resulting five-member committee meets with the CEO, CMO, and board chair to identify and interview desirable board candidates and propose a slate for the shareholder vote.

### Case in Brief: The PolyClinic
- 200-physician independent medical group based in Seattle, Washington
- Governed by a seven-member board, elected at large
- Physicians organized into four specialty divisions: primary care, medical specialty, surgical specialty, and hospital-based
- Board candidates selected by nominating committee assembled through special selection process

Source: The Advisory Board Company interviews and analysis.
Defining the Ideal Board Member

Once a nominating committee is assembled, it needs a clear guiding vision of the personal qualities and expertise it should look for in potential board members.

This vision has two components. First, the committee needs a clear sense of the qualities and experiences that every board member must possess. Some of these can be set as explicit requirements—for example, prior committee service or completion of certain educational requirements, such as a course at a local university. Others, such as the qualities listed on the bottom left, must be discerned by a nominating committee or others working to identify or screen potential board members.

At the same time, the nominating committee must conduct a gap analysis of the current board and determine which skill sets, demographic profiles, and/or perspectives are inadequately represented. Examples of what such a gap analysis might look for are listed on the right.

Note that, as the medical group’s strategy and market position evolve, it is critical to continually update the list of desirable board member characteristics relevant to each organization.

### Traits Needed in Every Board Member at All Times

#### Prior History
- Adequate time spent as a shareholder
- Prior committee service, other group leadership
- Completion of educational requirements
- Strong clinical, financial performance
- Absence of complaints related to quality, patient experience
- Leadership, board service in broader community

#### Personal Qualities
- Understands, shares stated group-level values
- Identifies with organization as a whole
- Capable of innovative, strategic thinking
- Not afraid to challenge peers in discussion
- Patient-centered
- Understands community needs
- Perceived as leader, able to influence peers
- Strong relationship-building, collaborative skills
- Comfortable with leading change
- High aptitude for, and open to, continual learning

### Traits That May Be Needed Depending on Current Board Composition, Strategic Concerns

#### Demographic Profile
- Specialty
- Geographic basis
- Full-time status
- Tenure in group
- Gender
- Age

#### Areas of Expertise
- Strategic planning
- Contract management and payer relations
- Principles of value-based care, health reform
- Medical group economics
- Physician compensation
- Pension, benefit, and staff planning
- Investment and capital management
- Financial document analysis
- Clinical quality, process improvement
- Hospital relations
- Expertise relevant to current strategic initiatives (e.g., analytics, ambulatory service center management)

---

1) Relevant to potential physician board members only, not external members.
2) E.g., business course at nearby college, national conference attendance.
3) Not every board member needs to have all of the characteristics and perspectives listed on the right, but all of these should be represented on the board; nominating committee can use the list on the right as a basis for a board member gap analysis.

Source: The Advisory Board Company interviews and analysis.
Continual Education

Investing in Board Member Education

While a strong guiding vision and process for selecting board members is essential, it is not enough to ensure a maximally competent governing board. It is impossible to fully predict market changes and board priorities two or three years ahead, and hence to select board candidates that possess all of the needed skills and expertise. Moreover, the necessary talent may simply not be available at the time of elections.

As a result, the strongest medical group boards are dynamic bodies able to engage in continual learning.

The left side of this page lists areas of knowledge and skills that board members should develop during the time of their service. On the right are listed tools and venues that medical groups can use to support board member learning in these areas. As an additional resource, the Physician Practice Roundtable will be publishing an online board member education toolkit in early 2015.

As one CEO, quoted on the bottom, points out, the education of both current and future board members may require a sizeable investment. However, it pays off in higher leadership engagement and better ability to set a reasoned strategic course for the group.

Key Knowledge and Skill Areas for Board Members

Knowledge

• Fiduciary responsibilities, nature of board governance
• Market position, key challenges
• National, regional, local trends and their underlying drivers
• Basics of contracting, including value-based contracts
• Regulatory landscape (state, federal)
• Individual areas of expertise (e.g., health reform, IT, accounting and finance, in-depth contracting, benefit design)

Skills

• Leadership and communication
• Negotiation
• Strategic planning
• Financial document interpretation
• Meeting agenda development, time management
• Delegation
• Conflict resolution
• Change management

Not Scrimping Where It Matters

“We’re investing hundreds of thousands of dollars in the education of current and future board members. We get almost no pushback on that—even those shareholders who’ve been skeptical about the costs are now enrolling in the educational programs because they have seen the impact.”

CEO, Large Multispecialty Medical Group

Source: The Advisory Board Company interviews and analysis.
The final step to elevating board member talent is ensuring that board service is appropriately rewarded.

Board member compensation is becoming more common. This pie chart shows 2014 survey results from large independent medical groups that do not have all-shareholder boards. More than half of these groups compensate board members for their time.

Of those that do, the vast majority offer an annual or monthly stipend rather than an hourly rate. This is an important way to recognize that board service involves more than just meeting attendance. Groups that understand the value of governance have many expectations of board members, such as meeting preparation, participation in educational events, and travel to external conferences. Stipend-based compensation removes barriers to engagement in these important activities.

Board member compensation must be generous enough to eliminate concerns about missed clinical time. Many groups calculate a monthly rate based on an estimate of the time required, seeking to compensate members for 100%, if not more, of likely lost income.

### Ballpark: Board Compensation Levels Heard in the Research

- **$1,000—$2,500**
  - Monthly rate paid to board members (higher for officers) at many independent medical groups
- **100%–120%**
  - Percentage of estimated lost clinical compensation represented by board member payments

### Sample Expectations for Paid Board Members

- Attendance at all board meetings, usually held on monthly basis
- Preparation for board meetings, careful review of all detailed materials provided in advance
- Participation in educational, training sessions
- External conference attendance
- Committee participation

---

1) Groups in which the board does not include all shareholders.

2) These numbers are anecdotes commonly heard in research interviews, rather than statistically validated results of a formal survey.
Designing Board Member Compensation Rates to Promote Group Orientation

When structuring board member compensation, multispecialty groups must answer an important question: Should specialists and primary care physicians (PCPs) be paid the same for their time, or should specialists receive a premium because of their greater loss in reimbursement for missed clinical time?

Pseudonymed Joseph Medical Group faced this question. On one hand, they could prioritize physician opportunity cost—effectively, putting the physician first. On the other, their board compensation model could reflect the fact that, from a group perspective, the value of specialist and PCP board members was the same.

Joseph chose to set an equal, blended rate for all physician board members. This decision sends an important message about the group-centered nature of board service. Specialists who consider their time more valuable than that of PCPs will not be attracted to an opportunity that does not compensate them higher. Those that do pursue board service are more likely to be truly invested in partnering with PCPs to provide value to the group as a whole.

Two Options for Structuring Board Member Compensation

Specialty-Specific Rate
- Specialists receive higher hourly pay rate for board participation than primary care physicians (PCPs)
- Attracts specialists focused on opportunity cost of leadership
- Promotes specialist partisanship, devalues PCP board members' service
- Option not selected

Blended Rate
- Primary care physicians, specialists compensated equally for board work at a rate blended across specialties
- Attracts system-oriented physicians focused on board value to group
- Promotes group focus, inter-specialty collegiality
- Option chosen

Case in Brief: Joseph Medical Group
- 300-physician independent medical group based in the South
- Medical group designed physician board member compensation to reflect group focus

Source: The Advisory Board Company interviews and analysis.
In addition to optimizing the size, composition, and skill sets of board members, medical groups must also appropriately scope the board’s role and its position within the organization. The remainder of this section will cover best practices for setting the board’s authority, delegating appropriately, and structuring board meetings to ensure maximal focus on issues which the board is uniquely suited to address.

**Six Elements of Effective Medical Group Board Structure**

1. Small elected board
2. Board membership representative, not constituent
3. Skilled, group-oriented board members
4. Extensive board authority
5. Effective delegation of board powers
6. Disciplined, focused board meetings

Source: The Advisory Board Company interviews and analysis.
How powerful should an independent medical group board be? More specifically, which decisions should the board be able to make on its own, and which should be determined by shareholders?

Some highly integrated independent medical groups have a simple answer to this question: The board should have the power to make practically all decisions without shareholder approval. Shareholder powers at such groups are limited to those required by law: election of board members, sale or dissolution of the company, and amendment of organization bylaws (which are generally brief, high-level documents that do not delve into specifics of physician compensation or other detailed and potentially controversial issues).

Some integrated independent medical groups interviewed for this publication grant shareholders a few additional powers, such as setting board member compensation or electing new physician shareholders. In practice, these powers tend to be largely symbolic.

---

**Highly Integrated Independent Medical Groups Have Highly Empowered Boards**

---

**Granting the Board Extensive Powers…**

Sample Bylaw Excerpts from Highly Integrated Groups

**Bend Memorial Clinic:**

“All corporate powers will be exercised by or under the authority of […] the board of directors, subject to any limitation set forth in the Articles of Incorporation or in a shareholder agreement authorized by the Oregon Business Corporation Act.”

**Spectrum Medical Group:**

“In the management and control of the business, property and affairs of the corporation, the Board of Directors is hereby vested with the power to authorize any and all corporate action, except when shareholder action is specifically required by the Maine Business Corporation Act, the Articles of Incorporation or these Bylaws, or except when otherwise required by a written agreement pursuant to §743 of the Maine Business Corporation Act.”

---

**…While Limiting Shareholder Powers to a Minimum**

Example Shareholder Powers in Highly Integrated Groups

1. Election and removal of board members
2. Sale or dissolution of company
3. Amendment of organization bylaws

---

Some Groups Grant Shareholders Additional Narrow Powers, including:

- Setting board member compensation
- Election of new physician shareholders
- Election of president, board chair

---

Source: The Advisory Board Company interviews and analysis.
For Many Groups, A More Complex Balance of Powers

However, highly integrated medical groups that grant nearly full decision-making powers to the board are the exception rather than the rule. The Physician Practice Roundtable’s 2014 Governance Survey suggests that, at many independent physician organizations, the balance of powers is far more complex.

In some cases, shareholder control does not have a large impact on the decision-making process. For example, while at a majority of surveyed groups shareholders must vote on the elevation of a new physician to shareholder status, typically these votes simply confirm that an individual has met shareholdership requirements clearly spelled out in the bylaws.

However, on other decisions the need for shareholder approval can significantly slow down or otherwise complicate decision making at the organization level. In particular, shareholder control over the three issues highlighted with arrows in the graphic—shareholder termination, acquisition or divestiture, and physician compensation—is likely to undermine the board’s ability to set and execute on group-level strategy. The following pages highlight challenges in these three areas.

Shareholders Often Making Key Group-Level Decisions

Proportion of Independent Medical Groups Requiring a Shareholder Vote, by Issue

1) Percentages for each decision type may not add up to 100% because not all organizations require a vote on every issue.
2) Groups in which the board does not include all shareholders.
3) Either in addition to, or instead of, board vote.
4) Average of responses to “Acquisition or Divestiture of Another Practice,” “Real Estate Divestiture.”

Areas where shareholder control is likely to undermine group-level interests

Market changes are increasingly pushing medical groups to adopt new standards for physician performance. Physicians who do not meet targets relating to organizational goals like quality, patient satisfaction, and utilization management—as well as those who generally resist change to their practice—can become a significant liability.

As a result, the question of shareholder termination has become more pressing, and controversial, for many groups. Too often, the requirement for shareholder approval can effectively paralyze board action by creating two highly unappealing options.

When the board identifies a shareholder as underperforming or culturally incompatible, proceeding with termination requires sharing a wide range of relevant information with the entire group. This is embarrassing for the shareholder in question and increases the risk of lawsuits against the board or the group as a whole.

The alternative is to stop termination proceedings and hope that informal actions can encourage the shareholder to make an independent decision to leave. While this is sometimes effective, the informal nature of this process compromises the board’s ability to clearly set performance standards for all shareholders.

```
No Need for the World to Know

“Bringing this up to a shareholder vote is essentially airing dirty laundry. That’s unfair. We are thinking about changing our by-laws to follow [The Advisory Board’s] Anthony D’Eredita’s advice—giving that authority to the board, with perhaps a more generous termination period than what we would use when there is cause.”

Dan McCormack, CEO
InterMed
```
Another area where shareholder control can undermine medical group strategy is acquisition or divestiture of large assets (such as individual physician practices or ancillaries).

A key characteristic of financial decisions of this sort is that they must be made with an eye to long-term, organization-level benefit, while in the short term they may result in increased expenses or loss of revenue. This impacts how physicians view such proposals, since the benefits may accrue after an individual leaves the group while the costs impact all current shareholders.

The case of pseudonymed Harman Medical Group illustrates this issue well. Over the past two years, Harman’s board put two proposals before the shareholders. One was for sale of ancillary facilities that were generating revenue at the time, but would become a liability as the group took on more risk-based payment contracts. The other was for purchase of a competing practice that was being targeted by the local hospital.

Harman shareholders rejected both proposals because of short-term costs and inconveniences associated with them. However, the group’s CEO believes that, in both cases, the group lost out on valuable opportunities.

### When Empowered to Decide, Shareholders Privilege Short-Term Considerations

#### Two Initiatives Proposed by Board for Shareholder Vote at Harman Medical Group

<table>
<thead>
<tr>
<th>Board Proposal to Shareholders</th>
<th>Two-Year Impact</th>
<th>Five-Year Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong> Sale of Ancillary Facilities</td>
<td>Loss of ancillary revenue reduces physician compensation</td>
<td>Reduced ancillary costs better under risk-based payment contracts</td>
</tr>
<tr>
<td><strong>2</strong> Purchase of Competing Medical Group</td>
<td>Cash outlay; historical animosity with competing group</td>
<td>Hospital prevented from purchasing, investing in competitor</td>
</tr>
</tbody>
</table>

#### Both proposals rejected by shareholder vote

### Case in Brief: Harman Medical Group

- 120-shareholder independent medical group based in the South
- Governed by 10-member board, but shareholders retain vote over key decisions including acquisition, divestiture
- Rapidly expanding risk-based payment portfolio

### Not a One-Time Incident

“We missed some great opportunities. That’s the price you pay for higher shareholder involvement in governance—no way around it.”

*CEO, Harman Medical Group*

---

1) Pseudonym

Source: The Advisory Board Company interviews and analysis.
A third area in which it is imperative for medical groups to maximize board authority and limit shareholder control is physician compensation.

Outlined on this page are four major reasons why shareholder control over compensation can pose serious problems for a medical group.

First, shareholder interests with respect to compensation can conflict with one another and, for some physicians, with group goals related to a value-based care strategy. Second, compensation is central to many other aspects of medical group strategy; as a result, lack of control over compensation compromises the board’s ability to perform most other aspects of its role. Third, groups often need to execute compensation change more quickly than shareholder control allows. And finally, the complexity of compensation models—both in general, and especially in groups with large risk- or performance-based contract portfolios—means shareholders are less likely to make informed decisions.

This is not to say that physicians outside the board should not be involved in compensation decisions at all. Most integrated groups use compensation committees as well as seeking shareholder feedback and support for the general direction of compensation change.

**Key Aspects of Physician Compensation Make Shareholder Control Unsustainable**

**Generates Conflict of Interest**
- Compensation changes affect shareholders differently based on current performance, specialty, practice setting, etc.
- Shareholders represent own interests; board members legally accountable to consider interests of entire group

**Often Requires Rapid Action**
- Payer, competitor moves that create need for compensation changes often happen quickly
- Delaying response until most shareholders understand market change can lead to missed opportunities

**Inextricably Linked to All Board Work**
- Group strategy, vision must be reflected in compensation incentives
- If shareholders control compensation decisions, board effectively unable to reinforce strategy

**Highly Complex**
- Diversity of contract types, metrics, specialties may lead to high complexity in compensation plans
- When presented to large shareholder group, complexity leads to confusion, indecision

**Too Much at Stake**

“In 2011, the market was changing and we needed different types of incentives. We lost some key physicians to competitors over this. Lesson learned: everyone understood that we needed to let the board do this so that comp changes can happen at a pace that’s aligned with the market.”

**Just Too Complicated**

“A lot of it comes down to the detail. The physicians on our compensation committee are able to work through that complex detail and make a recommendation to the board. While we value input from all shareholders regarding the comp model, this has proven the most effective way for us to make decisions.”

Jeff LeBenger, MD
CEO, Summit Medical Group, NJ

Source: The Advisory Board Company interviews and analysis.
The discussion in the previous pages suggests that, in order to act in a more unified and cohesive manner, many independent medical groups need to significantly expand the authority of their boards—especially in the areas of shareholder termination, acquisitions and divestitures, and physician compensation.

A board that has these powers can use them when needed to achieve key strategic goals. However, this does not need to mean complete centralization. Groups can let factors such as group culture, current strategic goals, and market conditions determine the extent to which the board uses its powers.

For example, the board at Proliance Surgeons, a large independent surgical group based in Seattle, is committed to the principles of “limited government” and decentralization. While the board has the power to make almost any decision concerning the group, it defaults to letting local care sites set their own course when possible. Currently, Proliance’s practices operate in a highly autonomous fashion. However, should the group move in a strategic direction that requires significant physician behavior change or major collective actions, the board has the power to make the necessary decisions and push the group forward.
Prioritizing Board Purview, Time

Boards Intended to Focus on Strategy—But Do They?

The more extensive a board’s authority, the more important it is for the board to prioritize its tasks. Most of a board’s time should be spent on responsibilities that only the board can fulfill—high-level strategic and policy decisions and other priorities relating to governance, as defined on page 19. Everything else should be left to board committees and the management team.

Medical group boards vary widely in how closely their activity matches this ideal. On average, groups responding to the Physician Practice Roundtable’s 2014 governance survey reported that their boards spend nearly half of their time on strategic concerns (plus another 12% on physician compensation, an issue that has both strategic and operational aspects). However, a closer look reveals that, while the five boards that could be described as “most strategic” spend two-thirds of their time on these issues, the five “least strategic boards” dedicate barely a quarter to them.

To maximize time spent on strategic concerns, and hence add greater value to the organization, medical group boards should focus on two key strategies: building structures that support effective delegation and improving board meeting discipline.

Large Differences in Board Focus Among Independent Medical Groups

Average Allocation of Board Discussion Time (Self-Reported)

N = 29 large independent physician organizations

Two Strategies to Prioritize Board Time for High-Level Decisions:

Element 5: Effective Delegation of Board Powers

Element 6: Disciplined, Focused Board Meetings

1) Strategic plan review and approval, contracting strategy, policy development.

2) Medical staff issues, practice operations.

Why do many boards allow management responsibilities to take up time that should be used for strategic and policy debate? Some groups may simply lack a strong enough management team. However, even when this is not the case, many boards struggle to delegate. While habit, personalities, or lack of awareness of a board’s proper role all play a part, there are also some structural reasons for this. Two in particular stand out.

First, if the board chair has executive responsibility—an arrangement frequently seen at independent medical groups—management concerns are more likely to be on the board’s formal and informal discussion agendas.

Second, large independent medical groups need to have extensive physician leadership, for multiple reasons ranging from winning shareholder trust to the need for clinical expertise on decisions pertaining to care delivery transformation. If the board is the only venue for providing physician leadership, then the board is likely to be involved in most issues, including ones that are very operational.

**Two Common Scenarios Leading to Excessive Board Focus on Management and Operational Issues**

- Board chair also serving as the CEO or president, charged with managing group
- May not separate own roles in governance vs. management; may use board as advisory body for management issues
- Few physician leaders in the group outside of board members
- Board drawn into all issues on which physician input, leadership is necessary

**Board Chair Directly Responsible for Management**

**Board Is the Only Venue for Physician Leadership**

**Overextended Board**
- Board highly involved in management
- Significant portion of board discussion centers on operational details

Source: The Advisory Board Company interviews and analysis.
To take management issues off the board’s agenda, a key first step for many groups is to separate the roles of board chair and CEO. This creates robust, dedicated leadership over the separate governance and management functions. These roles are outlined in some detail on this page.

A few things are worth noting. First, the work of a board chair requires significant skills and attention. It should be performed by a physician and requires significant dedication of the physician’s time. By contrast, the CEO need not be a physician.

Second, while the board chair leads the board, he or she is not the CEO’s direct supervisor. Rather, the CEO reports to the entire board.

Some organizations can separate governance and management functions while still having these leadership roles performed by the same individual. This setup requires this individual to have a thorough understanding of the difference between the two roles, as well as strong skills and experience in both. Such leaders can be difficult to recruit, often presenting succession challenges.

### Establishing Two Essential Leadership Roles

#### Board Chair: Leading the Governance Function
- Physician leader, 0.5-0.75 FTE
- Shapes board, group culture
- Sets board meeting agenda to ensure governance focus; facilitates effective discussion, decision making
- Represents board to shareholders; may support CEO in resolving physician issues
- Cultivates current, future board members

#### CEO: Overseeing Management and Elevating Governance Issues to the Board
- Need not be physician
- Must have strong business, practice management expertise
- Carries out board decisions
- Reports to entire board
- Responsible for all aspects of management
- Brings governance issues to board attention (e.g., strategic plan, need for policy change)

Source: The Advisory Board Company interviews and analysis.
Boards may also become excessively involved with management issues if non-board venues for physician leadership are absent. This can be remedied by creating a robust, effective physician committee structure. A good example comes from The PolyClinic in Seattle.

The PolyClinic has designated two different committee types. Six standing governance committees support the board in executing core governance functions such as quality oversight, strategic planning, and pension and benefits.

By contrast, management committees serve as venues for physicians to support and provide input to the administrative teams on a wide range of operational issues—from marketing to facility planning. These committees can be formed ad hoc and their number is not limited; currently, the group has over 15 management committees.

Note that only one PolyClinic board member serves on each governance committee, but no board members are expected to serve on management committees. Combined with the sheer number of committees, this allows for two-thirds of the group’s physicians to participate in a leadership position within the medical group.

### Distinguishing Two Committee Types at The PolyClinic

#### Multiple Committees Ensure High-Level, Strategic Focus for The PolyClinic’s Board

**Governance Committees**

Standing committees support board on six core oversight responsibilities:

1. Quality
2. Finance
3. Compensation
4. Strategic planning
5. Pension and benefits
6. Peer review

#### Management Committees

Ad hoc committees provide physician input into management issues, including:

- Physician recruitment
- Marketing
- Technology
- Facilities
- Care management

Source: The Advisory Board Company interviews and analysis.
A large number of committees could easily cause the board to spend a disproportionate amount of time reviewing committee work. However, The PolyClinic’s committee structure is designed to limit the board’s supervisory burden by reinforcing the distinction between governance and management.

The PolyClinic’s six governance committees, which focus on issues pertaining to high-level oversight of the group, report directly to the board. The group’s management committees, on the other hand, do not: For the most part, they operate within limits set by the board and/or the management team, and their recommendations can be enforced directly by the latter, without formal approval. If a management committee feels the need to go beyond those limits—for example, to request an over-budget expenditure—it must bring the proposal to an appropriate governance committee, which will review it and, if needed, elevate to the board. As a result, the board is shielded from the direct responsibility of resolving management issues while leaving plenty of room for physicians to contribute and lead in management.

Not All Committees Need to Report Directly to the Board

Committee Reporting Structure at The PolyClinic

Board
- Regularly reviews governance committee reports
- Relies on administrators and governance committees to ensure management committees comply with designated purpose
- Does not usually review management committee reports

Governance Committees
- Report regularly to the board

Management Committees
- Usually do not report up to any governing body
- Administrative leaders implement proposals directly
- Report to governance committee when proposals do not align with current board guidance

1) E.g. committee proposal requires policy change, above-budget expenditure.

Source: The Advisory Board Company interviews and analysis.
A board that has effectively delegated management tasks is free to focus on high-level strategy. However, even under these circumstances, board discussions can easily slip into complex but ultimately irrelevant detail, or veer away from the hard work of decision making.

This means wasting two critical resources: the board’s time, which needs to be prioritized for pressing governance issues, and the engagement of valuable board members, who can become frustrated with inefficient board meetings and lose interest in board service.

To avoid this, high-performing boards focus on constantly improving meeting discipline.

**Two Reasons to Focus on Board Meeting Discipline**

- **Prioritize Time for Most Pressing Governance Issues**
  - Board meeting time limited, has high cost in physician member compensation, lost clinical time
  - Board discussion that veers into management means less time for higher-level debate, temptation to micromanage

- **Maintain Board Member Engagement**
  - Inefficient board meetings can leave board members frustrated; may lead talented physicians to prefer spending time on patient care over leadership
  - Loss of interest in board service poses danger to long-term quality of organization’s governance

---

**Wasting a Valuable Resource**

“It’s happened more than I care to admit: we meet, we talk, we go off on tangents that seem urgent but really aren’t—and before you know it, the meeting is over and we didn’t decide anything. It’s just not a good use of expensive physician time.”

*CEO*

*Large independent medical group*
The most critical strategy for strengthening board meeting discipline is regular self-review.

Many boards perform an annual, written self-evaluation. However, at Bend Memorial Clinic, the board conducts a verbal self-review at the end of every meeting. All board members are put on the spot to express their opinion of the meeting’s effectiveness as well as their own and their peers’ level of preparation and contribution. The self-evaluation is immediate and fully transparent.

This is a more personally challenging, and potentially uncomfortable, approach than the more typical, largely anonymous annual self-review. However, it is also more effective: a board member who was criticized by peers in an open conversation for failing to prepare for the board meeting is likely to do his or her homework the next time.

Regardless of the method used, regular self-review is critical not only for improving the next meeting, but also for ensuring that the board fulfills its mission as a strategic and learning body.

### Bend Memorial Clinic Board Uses In-the-Moment, Verbal Self-Evaluation

#### Three Elements of Bend’s Self-Review for Board Meeting Effectiveness

<table>
<thead>
<tr>
<th>In the Moment</th>
<th>Board self-evaluation takes place immediately at the end of each board meeting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verbal and Transparent</td>
<td>Conducted in open conversation, with all board members present, rather than in writing</td>
</tr>
<tr>
<td>Reviewing Both Entire Board and Individuals</td>
<td>Board members asked to comment on meeting effectiveness, peer preparedness and contribution</td>
</tr>
</tbody>
</table>

#### Sample Self-Evaluation Questions for Board Meeting Effectiveness

- Was this meeting effective?
- Did we select the right agenda items?
- Did we allocate our time appropriately among the agenda items?
- Were the materials you received to prepare for this meeting adequate?
- Were you prepared for this meeting? Were your peers?

### Case in Brief: Bend Memorial Clinic

- 65-shareholder independent medical group, based in Bend, Oregon
- Governed by nine-member board, including seven physicians and two voting external members
- Board conducts verbal self-review at the end of each board meeting of the meeting’s effectiveness

### Making a Difference

“I expect to see measurable impact from our new individual review initiative. If we have board members who are not prepared, they will be prepared. For those who do not make a change, the nominating committee would identify replacement options.”

*Greg Hagfors, CEO*  
*Bend Memorial Clinic*
In addition to self-evaluation, effective boards draw on a variety of tools to improve their performance. A particularly valuable practice for increasing the productivity of board meetings is the use of a consent agenda.

A consent agenda consolidates items requiring minimal attention—committee reports, meeting dates, final approval of proposals that have already been discussed, etc.—into a single list. Instead of reviewing each item separately, the board votes to approve the entire consent agenda and then moves on to more substantive discussion (the “real” agenda). This can save significant amounts of time and energy, especially for groups that have multiple committees reporting to the board.

The consent agenda must be circulated well in advance of the meeting. At the beginning of a meeting, any board member can request to move an item from the consent agenda and onto the “real” agenda. These steps ensure that important items do not get rubber-stamped as part of the consent agenda, either accidentally or intentionally.

---

**Using a Consent Agenda to Streamline Board Meetings**

**Consent Agenda Saves Time Too Often Spent on Routine, Uncontroversial Items**

**Sample Consent Agenda**

I. Items Requiring Action

II. Committee Reports, Minutes

III. Other Routine Items
  - Informational items
  - Final approval of proposals that have been thoroughly discussed previously
  - Dates of future meetings

**Key Elements of Consent Agenda Utilization**

- Full agenda, including consent agenda, should be disseminated before board meeting
- Board meetings must begin by asking whether anyone wishes to move an item from the consent agenda to the regular agenda
- Board should then move to adopt the consent agenda and proceed to the regular agenda

---

**Tool in Brief: Consent Agenda**

- Consolidates non-controversial items typically found in board agendas to be dealt with in single up-or-down board vote
- Any board member can request to move a consent agenda item to full the agenda

---

**Far More Efficient**

“We started using a consent agenda about a year ago, and it made a huge difference. We were spending too much time on updates. Now it takes no more than 30 to 60 minutes to get through all the approvals and updates, so we can use the rest of the time for substantive strategic discussions.”

Dan McCormack, CEO
InterMed

---

This page offers a summary of the six elements of an effective independent medical group board. The discussion across the previous pages has focused on defining these elements and providing case studies and examples of their implementation. However, the journey from a typical independent medical group board to one that possesses these six characteristics can be complex. Successful leaders must have a vision not only for the most desirable board model, but also for the steps needed to secure physician support, prepare board member talent, and establish a new leadership culture.

The next section of this publication provides a detailed case study of one independent medical group’s journey from a constituency-based, management-focused, and passive board to a strategic and effective governing body for the organization.

### Six Elements of Effective Medical Group Board Structure

1. **Small, elected board**
   - Board size of 10 or fewer members
   - Fair elections that ensure adequate turnover

2. **Representative, not constituent**
   - Board members elected from entire group, at large
   - Constituency interests represented through other means

3. **Skilled, group-oriented board members**
   - Board members recruited, educated, compensated to ensure high skill level in governance

4. **Extensive board authority**
   - Board empowered by bylaws to make majority of decisions for group

5. **Effective delegation of board powers**
   - CEO, board chair roles that distinguish governance, management
   - Strong, efficient committee structure

6. **Disciplined, focused board activities**
   - Commitment to ensuring that board meetings achieve governance-related goals

Source: The Advisory Board Company interviews and analysis.
In addition to this publication, we offer independent physician organizations a range of additional governance resources.

These resources, available on Advisory.com in early 2015, will help independent medical group boards prepare for governance change, deepen shareholder and board member understanding of governance, support board member skill development, and conduct more effective meetings.

### Toolkit to Support Board Improvement Efforts

#### Board Transformation Diagnostic
Diagnostic questions to help independent medical group leaders and boards assess their organization’s governance strengths, weaknesses

#### Communication Tools
Talking points for executive leaders, board chairs to help communicate governance goals across the organization

#### Board Member Education Packet
Resources and literature focusing on governance tasks, board member role

#### Related Case Studies
Independent physician organization profiles focusing on innovative approaches to governance design

---

Source: The Advisory Board Company interviews and analysis.

Additional governance resources available on Advisory.com in early 2015
Implementing Governance Transformation
A Case Study
A Board in Need of Improvement

The final section of this publication is dedicated to a detailed case study of a group we have pseudonymed Springfield Medical Group.

Upon assuming his position more than 10 years ago, Springfield’s CEO recognized several flaws in the group’s governance structure. All board members were elected to represent specialty constituencies. Moreover, because in the past board seats had been used as a recruitment lever for specialty practices joining the group, board members represented constituencies of very different sizes and significance for the organization. The board’s ability to govern was also hampered by the absence of processes for screening board candidates to ensure that they had relevant governance skills. There were also no clear expectations that the board should focus on governance rather than management issues.

Not only was the board poorly equipped to govern, it was reluctant to do so. The board was created when the group initially came together under hospital ownership and had therefore served in a mostly symbolic capacity. Even after this ownership came to an end, the culture of the board did not change; it still saw its role as minimal, relying on the CEO to lead the group.

Three Problems in Springfield Medical Group Board Structure, Skill Set

Constituency-Based
- Board seats initially used as recruitment lever for specialty practices joining group, often regardless of specialty size

Unskilled in Governance
- No process to ensure board candidates had governance, business skills
- No expectation set for board to focus on governance rather than management

Reluctant to Govern
- Board initially created when group was owned by hospital; lacked real authority
- Even after officially empowered, sees own role as minimal

Resulting Governance Challenges
- Board members lack interest, skill for providing meaningful governance oversight
- Board discussions center on operations, lower-level concerns
- Board takes passive role, placing burden of governance and management responsibility on CEO

Case in Brief: Springfield Medical Group
- 150-physician independent multispecialty medical group based in the Midwest
- Went through multi-year process of governance, leadership restructuring to create more representative, group-oriented, skilled board

1) Pseudonym.
The CEO had a vision for reforming the board to address the issues just outlined. However, recognizing that the group was not ready for reform, he worked to lay a foundation for change.

At the time, several board seats were occupied by individuals who did not have a strong understanding of or skills in governance. This was a clear impediment to the board’s willingness to consider reform. The CEO’s first step was to identify promising physician leaders and encourage them to run for those seats.

His second step was no less important: In an attempt to cultivate the future cadre of skilled board members, the CEO worked to create an internal educational curriculum—the Leadership Academy. The academy drew strong physician interest and provided an opportunity to identify and groom future leaders.

Several years after the academy was established, the group was ready to consider actual governance reform. Now the CEO’s task was to share his vision with all shareholders across the organization—who would have to vote on any changes to governance.

Three Initiatives Help Ready Organization for New Board Structure

Springfield Medical Group CEO

**Influencing Board Composition**
- Proactively sought out high-quality physician candidates to challenge board members who detracted from culture

**Developing Physician Talent Bench**
- Created homegrown Leadership Academy to focus on finance, leadership, negotiating skills (open to any interested physicians)
- Observed academy participants, encouraged some to run for board

**Presenting New Governance Vision**
- Formulated vision for governance overhaul
- Met with all shareholders individually to ensure all questions, concerns were addressed

2000 2005 2010

Source: The Advisory Board Company interviews and analysis.
Compromises Necessary to Implement Board Transformation

Springfield was now far more ready for governance reform. Yet key compromises were still required to ensure shareholder acceptance.

One of the CEO’s goals—raising expectations for board members, as well as compensating them for service—built naturally on the earlier creation of the Leadership Academy, which had already helped shareholders recognize the value of leadership education.

However, another key goal—making the board representative rather than constituency-based—was far more controversial. Rather than dismantle specialty representation entirely, the board membership proposal ultimately approved by the shareholders was to rationalize constituency representation. The group created four large, uniformly sized specialty divisions and offered each division one board seat. They also added at-large and external board members.

Another compromise concerned the speed of rolling out these changes. To avoid the perception of a power play, the CEO proposed grandfathering the board for a year to ensure that current board members had an opportunity to run for re-election under the new rules.

Proposals Crafted to Ensure Acceptance, Smooth Rollout

 Proposed Board Structure Changes at Springfield Medical Group¹

<table>
<thead>
<tr>
<th>Least Controversial Goal</th>
<th>Most Controversial Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>CEO’s Goals</td>
<td>Compromise Proposal to Shareholders</td>
</tr>
<tr>
<td>Raise expectations for board member skill, interest</td>
<td>Proposed As Is</td>
</tr>
<tr>
<td>Move to representative, not constituency-based board</td>
<td>Reduce, Rationalize Constituency Membership</td>
</tr>
<tr>
<td>Change board composition as soon as possible</td>
<td>Roll Out Changes Over Two Years</td>
</tr>
<tr>
<td>Separate governance, management oversight (uncoupling board chair, CEO roles)</td>
<td>Postponed</td>
</tr>
</tbody>
</table>

¹) Pseudonym
²) Primary care, medical specialty, surgical specialty, hospital-based.

Source: The Advisory Board Company interviews and analysis.
After the board reform proposals were implemented, Springfield Medical Group experienced three significant, mutually reinforcing improvements in governance.

First, the board is now less constituency-based: four members represent specialty divisions, while three are elected at-large and another is recruited externally. As a result, the board is now much more oriented toward the needs of the organization as a whole.

The clear message that the board is now focused on organization-level strategy helps draw talented, strategically minded physicians to board service. The same goal is supported by new board candidate eligibility criteria—which notably include graduation from the group’s Leadership Academy and previous experience serving on a committee and/or as department chair.

With a higher-level mandate and stronger talent, the new board is much more willing to make major decisions for the group—something it was reluctant to do in the past. This has raised its importance in the eyes of shareholders. As a result, shareholders support investment in board member education and compensation, and there is also far greater general interest in pursuing board service.

![Group-Oriented, Representative Board Composition](image1)

**Three Mutually Reinforcing Positive Governance Changes**

**Current Board Characteristics at Springfield Medical Group**¹

- **Board Composition**
  - Four board members representing four broad specialty divisions
  - Three at-large board members
  - One external board member

- **Board Candidate Eligibility Criteria**
  - Must be shareholders for at least five years
  - Must be Leadership Academy graduates
  - Must have previous experience serving on a committee and/or as a department chair
  - Cannot have quality complaints against them

- **Shareholder Support for Board**
  - Recognize board’s role in making major decisions for the group
  - Willing to invest in board member education
  - Support board member compensation of $2,500 per month
  - High level of interest in board participation

---

**Mission Accomplished**

“The board I have now versus five years ago is completely different. The quality of our interactions is far higher. And people now actually campaign to be on the board. It’s very rewarding to see this unfold.”

CEO

*Springfield Medical Group*

¹) Pseudonym.

Source: The Advisory Board Company interviews and analysis.
For the past decade, Springfield's physician CEO has also served as board chair. With the board playing only a minimal role, having a physician CEO both manage the group and lead the board was seen as essential to ensuring that the organization was truly physician-led. However, the dual role prevented full differentiation between governance and management, allowing management to become part of the board's work. In addition, as the organization began considering its need to identify a successor to the CEO, it became clear that a physician leader able to execute both roles effectively would be challenging to find.

To accept separation of the role and the potential for a non-physician CEO, shareholders needed to see other physician leadership in the group. Strengthening the board was critical for sending this message. To further elevate physician leadership, the CEO and board also created three new physician-staffed committees and two medical director roles.

These proposals were accepted by Springfield's shareholders. As a result, the board was able to separate the leadership roles, recruit an effective physician CEO, and deepen its own focus on governance.

With Stronger Board, Springfield\(^1\) Ready to Separate CEO, Board Chair Roles

Change in Senior Leadership Roles, 2012

<table>
<thead>
<tr>
<th>Previous Model</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician CEO/Board Chair</strong></td>
</tr>
<tr>
<td>Physician executive serves as both CEO and board chair</td>
</tr>
<tr>
<td>Single physician role causes conflation of governance and management functions</td>
</tr>
<tr>
<td>Limited talent pool for recruiting CEO’s successor</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Transition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elevating Physician Leadership</td>
</tr>
<tr>
<td>Elevate role, talent quality of physician board members</td>
</tr>
<tr>
<td>Create three new physician committees focused on operations, finance, quality</td>
</tr>
<tr>
<td>Create two new medical director roles</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>New Model</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician Board Chair</strong></td>
</tr>
<tr>
<td>Experienced physician leader</td>
</tr>
<tr>
<td>Leads board in governing</td>
</tr>
<tr>
<td>Sets group vision, ensures physician-driven culture</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Non-Physician CEO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has business background</td>
</tr>
<tr>
<td>Accountable for management and operations</td>
</tr>
</tbody>
</table>

Historically, having physician in CEO role seen as essential because board struggled to provide strong physician leadership; this resulted in dual CEO/board chair role

---

1) Pseudonym.

Source: The Advisory Board Company interviews and analysis.
Seeing Significant Improvement in Board Effectiveness

As a result of the vision, preparation, and effective compromise solutions described on the previous pages, today Springfield’s board possesses the six characteristics outlined in Section II of this publication.

The composition of the organization’s board has changed dramatically. Constituency representation has been reduced and rationalized, allowing for a greater focus on group-level strategy. Board members today bring far greater expertise and skill to the table.

While the board possessed significant formal powers even prior to the reform efforts described previously, stronger board member talent now allows the board to fully embrace its governing authority. Recognition of the significance of the board’s role further encourages board members to ensure that meetings are effective and stay at an appropriately high level of discussion.

These changes to the structure of Springfield’s board have also helped prepare the organization for the critical step of separating the CEO and board chair roles. If this takes place, it will in turn allow the board to delegate its management responsibilities much more effectively and to deepen its focus on governance.

Springfield Medical Group\(^1\) Possessing Key Elements of Effective Board Structure

1. Small, elected board
   - Eight-member elected board
   - Includes one external board member

2. Representative, not constituent
   - Half of board members elected at-large or recruited externally

3. Skilled, group-oriented board members
   - Board members receive education, leadership training
   - Board service draws talented physicians

4. Extensive board authority
   - Board empowered by by-laws to make majority of decisions for organization
   - Embraces its governance role

5. Effective delegation of board powers
   - Separate physician Board Chair, non-physician CEO roles

6. Disciplined, focused board activities
   - Board members holding high-level conversations focused on strategy

---

1) Pseudonym. Source: The Advisory Board Company interviews and analysis.