



The American Hospital Association's

**CENTER FOR
HEALTHCARE
GOVERNANCE™**

Governance of Physician Organizations: An Essential Step to Care Integration

Monograph Series

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AHA Center for Healthcare Governance

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Blue Ribbon Panel on Governance of Physician Organizations

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Introduction

The transformation of health care toward more integrated and accountable delivery systems has brought physician practices and other physician enterprises into health systems, as partners and collaborators, in unprecedented numbers. With this shift has come a need to rethink and engage the leaders of these medical enterprises in new roles, including their participation in physician organization governance.

This report shares findings from a study of governing physician organizations in developing systems of care. The study is among the first to explore this work from the perspective of physicians, who talk candidly about issues and challenges and provide insights about the evolution of physician involvement in governance and leadership at a historic moment of change in health care.

What you read here may surprise you. And, as they did for many who participated in this study, the findings shared in this report will confirm how willing and decisive leaders in today's health care organizations are building a new system of care devoted to improving the health of those it serves. Their experiences provide lessons for leaders and board members in all health care organizations.

This study contributes to ongoing work by AHA's Center for Healthcare Governance and Physician Leadership Forum to examine governance and leadership of health care organizations in transformative times. A high-level overview of this report appears in Report-At-A-Glance on page 8.

Overview of the Study and Findings

In 2012 the AHA's Center for Healthcare Governance published its third Blue Ribbon Panel report, *Governance Practices in an Era of Health Care Transformation*, based on a series of interviews with hospitals and health systems going through transformational change. The report and associated tools to assist hospital and health system boards better guide their organizations through the significant challenges confronting them is available at <http://www.americangovernance.com/resources/monograph/pdf/12-brp-governance-practices.pdf>.

The 2012 study identified “physician engagement and integration” as a key challenge health care organizations and physicians must meet to thrive in the new environment. Effectively addressing this issue goes beyond aligning incentives among physicians and hospitals and requires moving toward clinical integration, the study concluded. At the heart of this challenge is development of a true partnership between health care organizations and physician leaders from the bedside to the board room—partnerships that prepare and engage physicians in shaping new approaches to care delivery and playing key roles in organizational governance and leadership.

Governance of Physician Organizations: An Essential Step to Care Integration builds on the Center's earlier study, with generous support from Center affiliate member Hospira, Inc., and ongoing work conducted by the AHA's Physician Leadership Forum. The purpose of this study is to examine governance structure and function in a diverse set of physician organizations—entities designed to engage physicians in the leadership, governance and decision-making of the clinical care enterprise.

Thirty-one physician leaders, executives and board members of six organizations were interviewed and shared their insights for this study (see a description of Study Organizations in the Appendix on page 27). Each organization also completed a survey and provided documents describing itself and its board. Charts profiling key attributes of each of these organizations and their boards appear on pages 28-30. A panel of physician organization leaders and board members and other governance experts also convened to evaluate interview results.

The study aims to:

- foster better understanding of governance practices of physician organizations and how they are evolving;
- identify and share learnings that can be broadly applied to governance of these organizations; and
- spur development of tools and resources that can help physician organizations further strengthen and improve their governance.

Report-At-A-Glance

This report has seven sections. The **Introduction** discusses how this study builds on other work conducted by AHA's Center for Healthcare Governance on governance and leadership in transformational times. It provides information on study aims, process and participants and summarizes key findings.

The second section, **Observations about Study Organizations**, discusses characteristics such as size, structure, and ownership and control of the six organizations that participated in the study.

The third section, **Observations About Study Organization Governance**, looks at the varied approaches to governance structure and function in these organizations to provide a snapshot of how governance and leadership adapts as these organizations mature. Board member selection, board committees, board meetings, education and other practices are discussed here. Gaps in governance practices also are identified.

Section four, **Evolution of Physician Organizations and Their Governance**, shares observations from participants on how physician board members and leaders in

these organizations grow into their roles. It highlights “defining moments” in governance and leadership that propelled these organizations to new levels of performance. This section also discusses evolutionary paths organizations may travel as they mature and includes an exercise other physician organizations can use to analyze where they may be in their own growth and development.

Sections five and six summarize opportunities and challenges for governance of these organizations and the value physician organizations and their governance have for care systems and the patients and communities they serve. Section seven, **Next Steps**, discusses key findings and recommendations for continuing research and development of resources to help other physician organizations, such as independent practice associations, clinic-hospital organizations and multi-specialty medical groups, apply study results.

Major sections of this report include summaries of key learnings from the study and questions physician organizations can use to assess how their own organization's governance and leadership measure up.

The study initially intended to focus only on the structure and practices of boards in these organizations. However, this report also includes information about other related structures that support board work, such as leadership councils and clinical program committees that play an important role in creating and supporting new models of care delivery. This expanded focus provides broader perspective on how these organizations are both led and governed.

This study is not meant to be an exhaustive examination of governance in all types of physician

organizations. However, the combined contributions of study participants and the panel provide unique insight into how these organizations and their governance are adapting in a transforming health care environment. Key study findings:

- A strong, consistent governance and leadership focus on doing what's best for patients and communities is positioning physician organizations as significant drivers of improved quality and financial performance and as architects of the new care delivery system.

- Governance practices are evolving to meet the needs of physician organizations at different points in their development.
- While comparing governance of physician organizations with that of hospitals and health systems can be useful, the evolution of physician organizations may indicate the need for variation in governance practices from those considered most appropriate for hospitals and systems today.
- A culture that emphasizes inquisitiveness and the importance of understanding underlying causes for performance and outcomes supports good governance in physician organizations.
- Defining moments in the governance and leadership of these organizations have the power to move performance to higher levels with broader impact.
- More research is needed to better understand physician organizations and their governance and leadership.
- Education, tools and other resources should be developed for physicians and physician organizations to close governance gaps and support their capability to lead change in health care.
- Broad dissemination of study findings is needed to engage the field in examining the governance roles physicians and physician organizations play to better support their success in governance and leadership.

Observations about Study Organizations

Even within the six physician organizations in this study, the variation in size, structure, ownership and control, geographic location, stage of development and governance structure and practices was significant—perhaps not surprising in a sector trying to reinvent itself in the face of fundamental change.

Organizations include independent practice associations (IPAs) owned entirely by physicians; joint ventures between physician organizations and health systems; physician entities that are health system subsidiaries; and a fully integrated, physician

clinic-hospital organization. They range in age from less than five years to multiple decades.

The smallest and youngest organization comprises 160 physicians and the largest, more than 5,000. Patients served range from 120,000 to a million. Experience with risk contracting also varies widely: from little to none in younger organizations and those in more geographically dispersed locations to more than 50 percent of revenue being risk-based in more mature organizations in markets where payers also have been ready to share risk either partially or fully. Half of study organizations were for-profit and half, not-for-profit. All were multispecialty organizations.

Although some study participants are independently owned and controlled, all were affiliated with or part of larger health systems, which provide some level of investment or financial support. Several jointly conduct strategic planning and are working toward achieving a common vision with these systems that will enable them to focus on accountable care; better gather, analyze and use data; accept risk; and contract together with payers. All study participants describe their organizations as entities in transition. They see the value of a relationship with a health system, and recognition of that value is mutual.

“In the last three months the system board has asked our physician organization to assist with evaluating hospital medical staff credentialing,” says one physician executive. “This is a major new function for us and one more way that the physician organization has become critically important to the entire system.”

Observations About Study Organization Governance

Variations on a Theme

The variability in governance structure and practices among study organizations may reflect a journey in which governance evolves to support the needs of developing organizations. For example, board size ranges from seven to 25 members among participating organizations. The youngest and smallest board has only one committee and is just beginning an initial strategic planning effort for its

Key Learnings from the Study

- Broader governance competencies and outsider perspectives are needed to guide the design of new and expanding care systems and address emerging challenges.
- All study organizations use a representational approach to selecting board members. They acknowledge the benefits and limitations of this approach and are likely to continue using it to select at least some board members.
- There is value in matching governance practices to organizational needs at various stages of their development and in avoiding application of traditional biases from governance in other organizations.
- Most study boards have committees devoted to overseeing quality, credentialing and peer review, finance and contracting; all oversee aspects of physician compensation, and most have executive committees.
- Lively discussion, debate and willingness to challenge and offer dissenting views are governance strengths in study organizations.
- Asking tough questions of their peers is a duty and a challenge for physicians who govern physician organizations.
- Orientation and continuous learning are critical for these boards.
- Boards in the study frequently compensate their members for board and committee work.
- Handling conflicts of interest in physician organizations is an evolving and complex issue. Traditional approaches that made sense when physicians were competitors in their private practices may not be the right standards when they are employees whose interests are more aligned with the organization as a whole.
- Board member evaluation processes are still evolving in these boards.
- For boards in the study, governance practice gaps include;
 - understanding the difference between governance and management;
 - defining relative roles, responsibilities and authorities among boards and management;
 - limited use of skill and behavioral competencies in board member selection, reappointment and succession;
 - the need for deeper board infrastructure; and
 - the need for more self-reflection on board capabilities.

physician organization. It also is poised to add to its current complement of board members—who are now either system executives or board members of system hospitals with employed physicians—new members “who are actively engaged in the evolution of health care.”

A larger board in a more mature and growing physician organization is considering whether to take a more competency-based approach to board member selection, rather than continuing to draw members primarily from the physician-hospital organizations

(PHOs) and medical groups that are part of the system with which it is affiliated.

Areas of commonality and divergence in governance practices underscore that “one size does not fit all” and that different approaches to governing can be appropriate at different stages of organizational maturity. Board member selection, board committees, board meetings, education, term limits and conflicts-of-interest are among the governance structures and practices discussed below.

Board Member Selection

The need for more diverse governance skills and perspectives is prompting some boards of more mature physician organizations to seek different board candidates who can guide design of new systems of care that extend across communities, regions and even larger landscapes.

Several study participants cite the need for an outsider perspective in governance. As these organizations and their governance mature, some add community members, who are not as common on these boards as they are on hospital boards; others seek participation from physicians outside of the organization. All acknowledge the difficult learning curve required, especially for lay board members, to competently govern these organizations.

Boards of organizations in the study, at least in part, use a representational approach to selecting some or all of their members. “Representational governance” elicits a negative reaction from some executives and trustees. In the evolution of hospitals to health systems it can become an obstacle when it stands in the way of decisions such as closing excess facilities to achieve system optimization. On the other hand representational governance can, especially in earlier stages of organizational development, help build trust and broaden understanding of internal constituencies and needs. Because these benefits can be crucial at different stages of organizational maturity, study participants and panelists indicate that some form of representational selection for board members is likely to continue.

Some views shared by study participants reflect assumptions about whether governance practices are “good or bad.” Panelists caution against applying traditional biases from governance in other organizations to evaluating governance of physician organizations.

Panelists suggest there is value in matching governance practices to the needs of organizations at various stages of their development. For example, physician organizations could retain some level of representation in selecting board members, but discourage ‘representational thinking’ as a governance practice, panelists conclude.

Several study organizations report using specific criteria in considering board candidates, including prior participation in board and leadership work, a patient-centric focus, the ability to contribute new thinking and insight and diverse skill sets that include legal, financial and business expertise.

Some study participants are looking for broader competencies in their board members that reflect both professional skill sets and behavioral capabilities and cite the need for leadership training to develop needed skills. Certain key skills that study participants said are needed for governance, such as risk management or population health expertise, are not present yet among those staffing some study organizations.

Comments from study participants about board member selection appear in the box below.

Board Committees

Most boards in the study have committees devoted to overseeing quality, credentialing and peer review as well as finance and contracting. One study

Comments on Board Member Selection

“Local physician/hospital organization presidents serve on our board. As we have gotten bigger, the board table is starting to become unmanageable. But I keep coming back to the fact that they are the vehicle for communication with the local community of physicians, so I’m not sure I would want to change that.”

“We’ve developed a number of biases for good reason over the years in working with hospital and health system governance. One of these is that ‘representational governance is bad’...another is ‘term limits are healthy.’ I think from a research standpoint that’s still an open question, especially given the evolution of many physician organization boards.”

organization also has some 50 clinical program committees that set quality standards and clinical protocols that are being adopted by system hospitals, as well. The standards and protocols recommended by these committees are reported through the physician organization board to the system board. These recommendations also are sent out to the Medical Executive Committees (MECs) of system hospitals. If a MEC decides not to implement the clinical program committees' recommendations, which rarely happens, it must justify its decision to the system leadership and board. The work of the clinical program committees, with support at multiple levels of system governance and leadership, has resulted in demonstrable improvements in quality, such as no incidence of central line-associated bloodstream infections, ventilator-associated pneumonias or bedsores for two years at some system hospitals.

Study organization boards also have other mechanisms in place to ensure performance necessary to fulfill commitments to stakeholders. These include robust data collection capabilities and making data available to the board's Quality Improvement Committee to establish quality metrics, monitor performance and help guide development of care standards and practices.

Some study organizations also tie reporting of quality data to availability of incentives and participation in some contracting arrangements. One physician organization in the study that is part of a health system establishes quality metrics, reports on performance and provides incentives for its members. The system's accountable care organization (ACO) also has an incentive structure for physicians based on their performance. The physician organization provides physicians, who are clinically integrated with the physician organization, to the ACO. To be eligible for incentives physicians have to be electronically connected to the physician organization and provide quality data from their office practices monthly. The physician organization also receives quality data from physicians' hospital practices. If they don't report their office data, physicians get no bonuses and are dismissed from clinical integration. They remain in the physician organization but are excluded from the ACO and the

preferential contracts in which clinically integrated physicians participate.

One study organization uses an outlier process to monitor physician practice patterns. When these are "particularly abhorrent," the organization works with physicians to bring their practices in line with peers. If outlier physicians don't get their practices back in bounds they are referred to the board's Membership Committee. If performance is sufficiently egregious they go through a process to exit the group.

One longstanding organization in the study delegates authority over contracting to a management services organization that provides executive leadership and administrative support to the medical group, which focuses on care delivery and quality. As one board member and committee chair remarks: "We want the experts to do what they do expertly."

Most study organization boards use an executive committee to help plan full-board meetings; some of these committees meet more frequently than their boards.

All study organization boards are involved in overseeing aspects of physician compensation. A majority of study participants report having a board committee or subcommittee that handles this responsibility.

Study boards cite the importance of committees in driving the work of the board and influencing organizational performance.

Board Meetings

The frequency of board meetings varies from quarterly to monthly in study organizations, similar to the meeting frequency typical of hospital and health system boards. Use of consent agendas, ample time for discussion, education and deep dives into specific topics and spirited discussion are elements common to many study participant board meetings.

Study organizations frequently cite the lively exchange and debate that occurs at board meetings as a governance strength. Some suggest that careful management of board agendas and discussion items sometimes dampens the level of exchange

and limits the context board members have available to them to consider and address issues.

Panelists compare the routine exchange of differing opinions and willingness to challenge one another reported at physician board meetings with what happens at hospital and system board meetings. “Physicians tend to do a better job of thinking that dissent is good,” one panelist observes. “These boards seem to accept the notion that ‘we ask challenging questions and expect to be intellectually astute.’ I think too many hospital and health system boards are a little lax and fall into group-think.”

Other study participant observations on board meetings appear in the box below.

One study organization cites the synergy and shared culture and practices between its community board

and Leadership Council—an internal operating board made up of physicians and executives which works through the detail in areas such as credentialing and quality oversight and brings recommendations to the community board and its committees. The Leadership Council also meets twice yearly with the community board for strategic planning retreats.

Leadership Council physicians have an open invitation to attend meetings of the community board and its Finance Committee. As one executive puts it, “The bottom line is to make sure that the operational arm and community are adequately aligned and not being pulled in different directions.”

Board Education

Even though many of their board members are practicing physicians with prior organizational leadership experience, study participants cite the

Reflections on Board Meetings

“We have a featured topic at each board meeting that lends itself to further discussion and helps generate and develop the organization’s policies.”

“Each board meeting begins with a patient story and review of system accomplishments. We review System 2020 Vision Strategies and performance in key results areas and discuss performance that does not meet targets. Everybody knows what we think ‘winning’ looks like. Our physician organization has its own metrics, which we also review. For example, we look at revenue and costs by contract, so we know where we stand with each one and where our challenges lie.”

“Information is presented to our board in SBAAR format (situation, background, action, assessment and recommendations). You know the options, the pros and cons of going down different paths. When you display things like

that, people get it and you tend to avoid conflicts. When we come to loggerheads we typically have a pluralistic committee that works through the issues. I am always pleasantly surprised that when you present information in the right way and everybody gets to see it, people come to the same conclusions. It’s not rocket science.”

“Culturally it’s very important to have a super-majority required for board decisions. It changes the dynamic and promotes a different level of discussion and real sense of physicians owning things, rather than having input, which results in very different conversations.”

“A challenge I have as a physician leader on the board is to ask tough questions at board meetings. As a physician you understand the ground game. I look at it as a duty to ask the hard questions.”

critical importance of board orientation and ongoing education. Several view orientation as a multi-step process that provides context for new board members about both the organization and the larger health care environment.

Concerns about the need for continuous learning have prompted some organizations to set up formal training programs. One study organization is setting up a “university” to train future physician leaders. The curriculum will focus on topics such as strategy, financial models and cultural dynamics.

Study organizations note the positive impact education can have on board member engagement and the value of combining it with socialization. One study executive says that the social time built into his physician organization’s annual winter retreat “does more to enhance the board than anything else we do all year.” Study participants also acknowledge the responsibility board members have to educate themselves.

A physician executive in one study organization notes that education also is needed about how hospital systems become health systems. That’s a cultural change, he notes, that has to happen at the system level of governance.

For more from study participants about board education, see the box on the right.

Other Governance Practices

Most boards in the study limit service for their members to three, three-year terms. Some study boards comment on the downside of **term limits** and are thinking about lengthening terms for board service.

“We had a consultant who was very adamant that we have term limits for board members,” says one physician board member. “But we realized we were shooting ourselves in the foot. Leaders are leaders... there are good reasons why certain people have been on the board since its inception.”

Term lengths and limits for board officers range from one to three years; however, most study organizations do not have term limits for board officers.

Thoughts on Board Education

“We don’t leave education to chance. We have made sure there’s a proper process for identifying future leaders, orienting them, promoting them through the system and making sure they develop the necessary skill sets to move up and eventually get onto boards. Board members take in-depth courses (half-day sessions monthly over a year or two) on topics such as high-reliability organizations and patient safety. These courses have homework and the expectation that what is discussed gets implemented. Committee members also get in-depth education on their committee’s area of expertise. By the time you become chair of a committee you’re one of our experts.”

“After taking one of our board members to a national conference...for the first time he got in his car and drove thirty-five miles to a local system hospital to get on a videoconference so he could be face-to-face with us at the physician organization board meeting.”

“We have a formal orientation program, but here’s how I look at it—the 80/20 rule. If you decide to participate on the board, education is up to you as a member.... I really challenge myself to learn and grow. I’ve observed an open heart surgery and a C-section. I and other board members have done a lot of work personally researching, learning, reading and just trying to aid the learning curve.”

Unlike boards of hospitals and health systems, study organization boards frequently provide **compensation** to their members for board and committee work. As one study executive suggests, “We have very intentionally pollinated system board structures with physician organization board members. I don’t think we articulate very well the amount of time our board members are going to spend beyond just serving on the physician organization board.”

Some study participants report being very cognizant of **conflicts of interest** on the board, especially for employed physicians, and manage conflicts rigorously. However, in general, practices for handling conflicts of interest appear to be less than robust. They range from annual disclosure to dealing with conflicts “as needed.”

“Attending to conflicts is the kind of thing physicians don’t typically focus on, but it’s good governance practice,” says a physician organization executive and panelist. “And, physicians can very easily get into conflicts of interest.”

Half of the boards in the study report conducting some type of **board member evaluation**, although this practice is still evolving. “We’re not doing performance assessment currently other than in a rudimentary way,” says one physician executive and past board chair. “We are just beginning to explore how to give feedback to one another about being a better, more responsible board member,” says another medical group executive and board member.

Almost all study organizations report that their boards engage in **leadership development and succession planning**. However, the process often focuses more on physicians working their way up through successive positions of organizational leadership to get onto boards. As one board member observes, “Getting the right skills and competencies on the board is always an issue.”

Study organizations acknowledge the need for development at all levels. One organization is designing a mini-course that will provide more in-depth training for the board and key physician leaders, recognizing that identifying, developing and promoting leaders doesn’t happen on its own.

Governance Practice Gaps

Panelists identified several governance practice “gaps” for physician organizations. Some of these are associated with younger, developing organizations; others seem to be present regardless of a physician organization’s age or maturity. They include:

- understanding the difference between governance and management, since physicians are involved at both levels in their organizations;

- the need to define relative roles, responsibilities and authorities among boards and management (such as who hires and fires the physician organization CEO);
- more rigorous use of skill and behavioral competencies in board member selection, reappointment and succession;
- the need for deeper infrastructure (committees, outsider board members) to power governance in younger physician organizations and a better understanding of committee effectiveness, for example, in more mature organizations; and
- more self-reflection on board capabilities to drive improved governance.

“Given that physician organizations and their governance seem to evolve organically from within, their governance practices are idiosyncratic,” says one governance expert panelist. “I don’t know if a standard of best practice exists yet. We have to put physicians in stronger leadership positions and figure out the role of the physician in health system governance.”

How Do We Measure Up?

Boards and leaders can use the following questions to apply study findings to their physician organizations.

1. How do we select candidates for board service?
Can we blend a representational approach with selection based on specific competencies to achieve the benefits of both?
2. Do we use committees to drive governance work?
What committees does our board have and how do they contribute to advancing board and organizational performance?
3. Are board meetings and committee meetings substantive forums for communication, education and strategic deliberation and decision-making?
4. What type of orientation and continuous learning opportunities do we provide to those involved in our organization’s governance?
5. What governance practice gaps identified by this study exist in our organization? What can we do to address them?

Evolution of Physician Organizations and Their Governance

Growing into Their Roles

One of the most striking observations about study organizations and their boards is their strong focus on striving to consistently provide quality, safe, affordable care through adoption of evidence-based practices and attention to cost-effective care and service delivery. According to some panel members, this focus is not always front-and-center for physician organizations, especially in their early, developmental years.

“I think physicians want to do the right thing for patients,” one physician panelist says. “However, earlier in the development of a physician organization, the focus is on maximizing revenue and income to the group....When these groups come into a system, they fight for a seat on the board and make sure whatever is happening will not disadvantage them in any way. That was the top priority I observed. Physicians in these organizations are trying to preserve their independence...and they’re not immediately the most visionary board members.”

As these organizations grow larger and their boards expand to include non-physicians and community members, a transformation occurs, panelists note. With maturity and exposure to other types of board members, physician organization boards begin to be more “socially responsible” and focus more on earning trust and doing what’s right for the organization and the community.

According to one physician organization executive and panelist, “In smaller sized groups, initially it’s all about top-line revenue and that includes overtreatment and use of ancillary services. But, as these groups join systems they see a bigger picture. I wish I could have recorded some of the comments our physician leaders made recently as we decided to get into Medicaid managed care. It didn’t make sense financially, but everybody said it was absolutely the right thing to do for the community and that we all needed to step up and do our share.”

Key Learnings from the Study

- A strong focus on doing what’s right for patients and communities and exposure to outside board members with diverse perspectives and skills drive growth and development for physician organizations and their boards.
- These organizations and their governance are evolving along multiple paths. The pace and degree of evolution may be affected by factors such as organizational ownership, market dynamics, alignment and the need for care redesign and clinical integration, many times driven by “defining moments” in governance.

“Over the years our community board members have bought-in to the notion of physician leadership,” another physician organization board member and panelist observes. “Physicians have shown the community that they can lead. They can put aside their self-interest and do what’s best for the organization and the community. I think if you would survey our board you would find a tremendous amount of trust in physician leadership.”

“Our organization developed a ‘dual board’ model of governance purposefully,” a panelist from one study organization says. “We have clinicians on our community board and Leadership Council because they bring knowledge of the ‘ground game.’ They understand care delivery and bring perspectives that our community leaders don’t have. Our community board members rely heavily on our physician board members to understand how strategies and decisions the board is considering will play out when we all go back to work on Monday morning.”

Interconnected Development

Panelists suggest that physician organizations and their governance practices are evolving along multiple paths, such as those shown in the assessment exercise on page 20.

As one physician board member and panelist notes, “If you do the right things for patients and the community as the organization matures, it’s a positive feedback loop. The economics and job satisfaction come back your way. I think physicians have to find comfort with that, and the process takes time. The organization also needs to recruit physicians who understand that the focus is not on the money, but on the mission. That will accelerate the organization’s evolution as well.”

Ownership of the organization also may have an impact. Says one governance expert and panelist, “If you are a not-for-profit 501(c) (3), the world looks a certain way. If you are a for-profit and your board members are all shareholders and elected by shareholders, in my experience it’s a much longer evolution.”

Panelists cite the power of “defining moments” in the evolution of physician organization governance. Examples are included in the sidebar on page 18.

Panelists also talk about the impact that the trend toward centralization in health care systems may be having on physician organizations in those systems, some of which are moving toward one board that incorporates clinicians and community members to both streamline governance and create standardization of practices systemwide.

“I think health care systems have been very successful centralizing a lot of the business, IT and finance functions and less successful centralizing quality and clinical practices,” one physician executive panelist observes. “That’s because I don’t think health care organizations have a lot of credibility with physician groups at local levels. We’re trying to create regional physician organizations that will eventually set quality standards across the system.”

Participants also note that physician involvement at multiple levels of governance contributes to creating greater value across systems.

Evolutionary End Game

The evolutionary continuum may not be so much about decentralization to centralization, one panelist observes, but more about fragmentation to greater alignment and coordination around evidence-based patient care and population health management. Both care systems and physician organizations are going through this transformation, sometimes at different rates. Understanding how governance and an unrelenting focus on improving patient care affect the evolution of these organizations may be an important context for further study of physician organizations.

Is there an end game for the evolution of physician organizations and their governance?

One panelist suggests that study feedback underscores that there is no one model or road map for the evolution of governance in care systems. He cites emerging models such as expert boards composed primarily of professionals; clinical enterprise boards; and enhanced community-based governance. These models are all being used successfully by different types of care systems in different markets.

Other panelists cite the impact that state, regional and market dynamics, such as adoption of risk-based payment models, may be having on evolution of physician organizations and their governance. However, the impact some might expect—greater adoption of risk-based payment driving clinical integration and delivery system reform—is not always the case. One of the most clinically integrated study organizations operates in a market with little risk contracting. “We basically look at clinical integration as the right thing to do,” a physician board member and panelist from that organization remarks. “We were an early adopter of ACOs and lost money, but we want to be in that space in case these types of delivery and payment reforms come to our market.”

According to a physician executive and panelist from another study organization, “We’ve tried to shape payment reform with our delivery system. Time will tell if we are successful. If you transform one or two markets, other markets are going to take notice.”

Sidebar

Defining Moments in Physician Organization Governance

Boards have the power to lead their organizations to higher levels of performance with broader impact. Spurring adoption of new technology and clinical standards to improve quality and safety, changing organizational and board structure to attract new revenue from payers and deciding to move into accountable care organizations and accept risk are just a few of the defining moments in governance that were game-changers for study participants.

*“Our one finest moment was making a board commitment in 2004 that everyone would be on **electronic medical records** by 2008, even though at the time only about 3 percent of our specialists and 20 percent of our primary care physicians were using them.”*

*“Our system board went through a training process on **quality and safety** and basically said, ‘Quality and safety is a core value here. It’s one of the things we can never ever make a decision against.’ After that, system board members began realizing that several recommendations from our physician organization’s clinical program committees were not being implemented by system hospitals, which could ignore our committees’ recommendations. The system board then said that the clinical program committees would report through our physician organization board directly to the system board. Once that happened, there was no filter. The system board really empowered our clinical programs and the physicians that led them.”*

*“For the last decade our physician organization board has been driving our system’s quality and safety journey in mandating electronic health records and training on high-reliability and not waiting for the medical staff...our physician organization has taken the bold steps of moving into **ACOs and risk**.”*

*“We have had a couple of defining moments. One was regulatory issues with the Federal Trade Commission, which forced us to either fold our tent or adhere to the principles of clinical integration. The second was **getting an outsider onto our board** who started to ask questions and challenge us. That changed the tone of our board’s conversation from representing a constituency to what was in the best interest of the organization.”*

*“**Adding a primary care group and changing our bylaws to include primary care physicians among our leadership and board** led a large insurer to contract directly with us. The money moving through our organization went from pretty much zero to \$40 million in just a few years. We now have risk contracts, we are developing population health management strategies and we need outside expertise on our board to bring in other perspectives. We’re also starting to think about what the success of our organization and our health system together might look like—the complexity of our organization and its governance has just exploded.”*

A physician panelist from a long-standing physician organization in the study makes this observation about the physician’s role, “Physicians have led our organization’s charge in quality and safety and in adding value to the organization,” he says. “They

play a strong role in the governance and leadership of the organization and bring a unique perspective, a different mindset. In this spectrum of different kinds of organizations, is there an evolution happening where physicians are having more of a role in driving

change, and are organizations just at different places along the spectrum?”

Another panelist adds, “Do you get to a point where many of our health care organizations need to be led by clinicians?”

How Do We Measure Up?

Assessment Exercise for Physician Organization Boards and Leaders

The chart on page 20 indicates several paths along which physician organizations and their governance can evolve as they move through various stages of organizational development. For each path, ask participants to indicate a point along the continuum that they think best describes your organization. Indicate aggregate results for each path as shown by the red dots on page 20. Use the aggregate results to discuss the following questions:

1. Is our organization positioned where we want it to be on each path?
2. If not, why?
3. Where do we need to focus our efforts to achieve the greatest gains?
4. What steps do we need to take next to move forward?
5. Are our organization’s board members and leaders ready to move ahead?

Opportunities and Challenges for Governance of Physician Organizations

Perhaps one way to get organizations moving toward good governance, panelists note, is to focus on achieving internal alignment along the evolutionary paths outlined in the assessment exercise above. Organizations that achieve this alignment can better understand the high-performance behaviors that contribute to effective governance and leadership. While the definition of effectiveness may vary for different organizations at different stages of evolution, the end state for governance and leadership is the same: to design a health care system that meets the needs of the people it serves.

Key Learnings from the Study

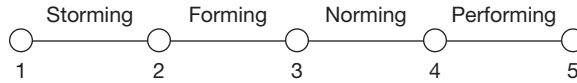
- Governance strengths physician organizations can leverage include a strong focus on delivering quality, safe care; willingness of physician board members to share dissenting opinions and apply intellectual rigor to their participation at board meetings; communication with the members of the broader organization and development of physician leaders who can participate in governing.
- Challenges include finding time to practice medicine and participate in governance and leadership and the potential loss of credibility among peers for physician leaders who do not practice medicine; an environment of accelerating change and risk; lack of alignment and trust between physician organizations and hospitals and health systems.

Panelists note several strengths that physician organizations can leverage to further improve their governance. Among them are:

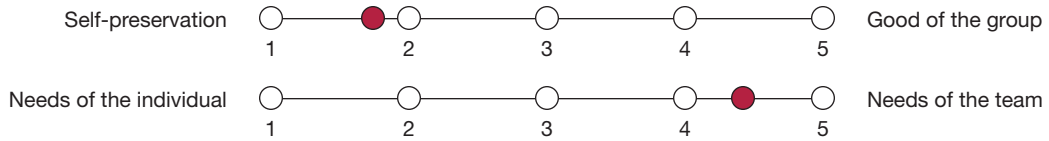
- a strong focus on delivering quality, safe care to patients;
- the preparation, willingness to share dissenting opinions and intellectual rigor physician board members bring to their participation at board meetings;
- efforts these boards make to communicate consistently with and engage the broader membership of their organizations;
- development of physician leaders within the organization who can assume governance roles; and
- the greater commitment that today’s system executives have, compared with a decade ago, to informed and engaged governance and leadership involving physicians who have real authority and participation in decision-making.

Assessment Exercise

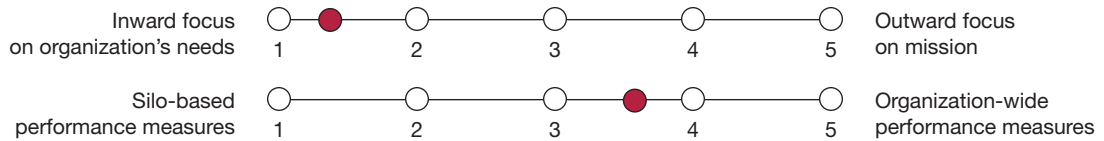
Stages of Organizational Development



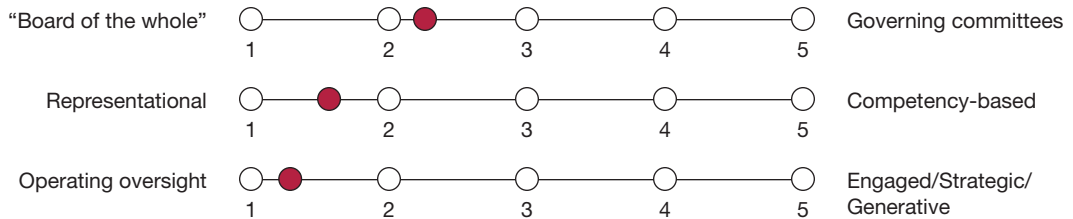
Individual Level



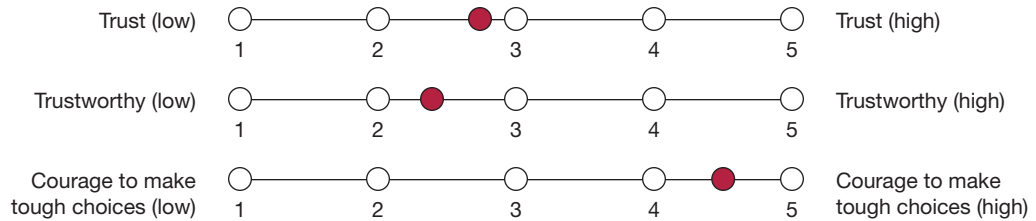
Organization Level



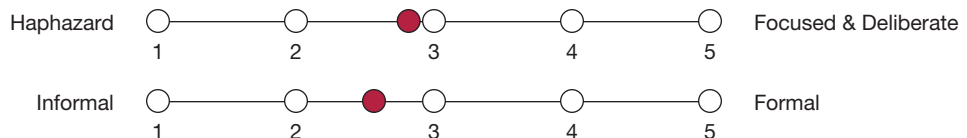
Board Level



Culture



Board Practices



Some of these strengths also present challenges.

“I would guess that physicians who are currently in leadership roles are older than those in other industries,” one panelist says. “You look around at most industries and their best leaders are in their forties. We try to cultivate leadership in health care, but we don’t actually give physicians room to be in those positions.”

“Physicians don’t have time,” another physician panelist observes. “That’s the fundamental problem and constant struggle—to maintain credibility as a practicing physician and still be involved in leadership.”

Movement away from a hospital-centric model of care delivery creates other dilemmas.

“Physicians are dispersed throughout the community,” one panelist notes. “We don’t have that physician lounge culture anymore, so how do you observe physicians’ behaviors, identify appropriate leaders and build physician leadership models?”

Both panelists and study organizations cite other challenges for physician organizations and their governance in the sidebar on the right.

According to one study board member, “Most physician organizations are for the benefit of the physicians. That’s a formula for failure once certain props, such as Medicare fee schedules, are no longer there. Our organization has always had the orientation that it will only succeed if it provides quality, cost-effective medical care in a manner that meets the needs of patients, as perceived by patients.”

Says one governance consultant panelist, “Most of the large systems I work with will tell you that the people who are leading hospitals are not the people who can lead the future of the delivery spectrum—care from birth through death, prevention and wellness, chronic disease treatment, medical homes, home care. We’re at a point of major change and physician organizations are growing into this type of leadership and governance.”

Sidebar

Challenges for Physician Organizations and Their Governance

- Continuous, accelerating change
- Transition from fee-for-service to fixed payment
- Governance oversight and setting strategic direction in an environment with lots of unknowns
- Assumption of clinical risk to drive assumption of financial risk
- Effective communication with the broader physician group to achieve internal alignment
- Lack of alignment and trust between physician organizations and hospitals and health systems
- Investment in physician leadership development and continuous learning
- Need to optimize system integration by reducing overlap and redundancy of functions such as clarifying quality oversight roles among physician organizations, hospital medical staffs and hospital and system quality committees
- Access to data and business analytics to understand and apply data to decision-making

Panelists see an opportunity for boards of physician organizations in systems to learn about and adopt governance best practices.

“There’s hundreds of millions of dollars of physician revenue flowing through our organization, and it’s nice to be able to stand up and say that an external auditor says everything ties out,” says one physician organization executive and panelist. “But for the first 10 years we didn’t do that, and when I talk with other physician organizations they’re usually not even thinking about it. I learned that we needed to create

Sidebar

Principles of Good Governance

1. Governance becomes more robust and mature as organizations themselves grow and develop.
2. No single evolutionary path or model of governance will work in all organizations and care systems: for example, clinical enterprise boards, expert boards, and enhanced community boards can all play roles.
3. A relentless focus on mission—providing quality, safe care for patients—brings clarity and impact to governance structure and function.
4. Boards should adopt a competency-based approach to member selection, member and leader development, performance evaluation and board decision-making.
5. Boards should seek and balance diverse member competencies to ensure necessary perspectives are present at all levels of governance to meet the needs of the patients the organization serves.
6. A robust board culture incorporates discussion, debate, and dissenting opinions; advance preparation, intellectual rigor and continuous learning are expected for participation in governance.
7. Boards can lead their organizations to higher levels of performance by making and enforcing tough, data-driven decisions and responding productively to “defining moments.”
8. When clinicians, outside experts and stakeholders govern collaboratively, the outcomes are more robust and sustainable.
9. Formal, rigorous development, performance evaluation and succession planning for physicians in leadership and governance roles are essential for their meaningful participation in the transformation of health care.
10. Effective boards have credibility with the stakeholders they serve.

an audit committee of our board, and we’ve modeled ourselves after the system board in this regard. I tell my colleagues not to wait to create this kind of discipline.”

Even though all physician organizations are at different places in their life cycles they can benefit from broadly applicable principles of good governance, such as those listed in the sidebar above.

How Do We Measure Up?

- What opportunities and strengths can our board leverage to continue to improve its performance?
- What key challenges must we overcome to govern more effectively? Are they the same or different than those reported by study organizations?
- How can applying the governance principles identified in the study result in governance work that has greater impact on our organization’s success?

Key Learnings from the Study

- Physician organization governance drives value for patients and health care organizations by championing a relentless focus on quality, safe, cost-effective care.
- A vision of providing the highest quality care and a commitment to being the best at delivering it can provide common cause and alignment for physicians and health care organizations.
- Not engaging in crucial conversations, being perceived as self-serving and failing to base decisions on data and evidence are some ways governance can impede organizational success.

Value of Physician Organizations and Their Governance

Panelists and study participants talk about the growing value physician organizations and their boards are demonstrating to their organizational partners and key stakeholders.

“For the first time in our monthly operating report we were able to show recently that our organization’s physicians provide the largest contribution margin and have the lowest alignment costs for our system,” says one physician organization executive and panelist. “I suspect that when we distribute our shared savings back to the larger organization our cost to the system will be zero.”

A physician organization board’s willingness to make tough decisions that change the direction of the organization is another way governance adds value, study participants note. “When you have physicians making those decisions, it’s really hard for rank-and-file physicians to say, ‘It’s not fair’ or ‘I don’t like it,’” a study organization executive and panelist says. Other ways physician organization governance adds value appear in the sidebar on the right.

Sidebar

Ways Physician Organization Governance Adds Value

- Developing a vision that stays ahead of the curve
- Keeping the focus on and setting high expectations for care quality, safety and outcomes
- Helping their organizations deliver better care at lower costs
- Challenging management and letting the organization know when more work needs to be done
- Ensuring physicians have the tools and skill sets required to succeed in the market
- Providing a point of accountability for physician compensation oversight
- Identifying metrics and measuring performance against them
- Promoting performance transparency that drives improvement in quality and the patient experience of care
- Using data-driven decision-making and decision-support resources
- Engaging in continuous and self-motivated learning
- Involving physicians in ways that elevate their engagement and participation in health systems
- Providing ways for physicians to have broader impact by addressing population health issues
- Lending credibility and validity to organizational direction and decision-making
- Engaging physician board members in communication with the broader physician group

What powers governance that adds value? One study organization credits board development of a compact that identifies obligations both physicians and the organization have to mutually support each other. Having a common purpose and a shared mission—a “True North” against which progress can be measured—also contribute.

“Our mission is part of every meeting our organization has,” says a physician executive and panelist. “It’s part of almost every conversation. I hear people all over the organization using it.”

“People say that getting physicians to work together is like herding cats,” another physician organization executive and panelist remarks. “I get offended when people say that. What do you do to herd cats? You give them catnip—something they want. For doctors you establish a vision of delivering the highest quality care and being the best. Tell doctors you want to be the best and prove it, and they will follow.”

Of course the value coin has two sides—one that adds value and one that detracts from it. Panelists offer warning signs and examples of how boards and physicians on them can impede their organization’s success in the sidebar on page 25.

Steps physician organization boards can take to move governance to the next level include:

- Defining and driving organizational culture.
- Asking the big fundamental questions: “What business are we in?” “Do we have everything aligned to take care of people and help them be healthier?”
- Tapping into the power of dialogue among board members and with stakeholders.
- Being driven by doing the right thing for patients.
- Understanding that, if empowered and encouraged, physicians can play a significant role in transforming health care and will step up and partner with executives to bring value to the change process.
- Supporting the innovative work physician organizations are doing to create new models of care.

- Understanding that quality really matters and that physicians are the appropriate agents to drive change.
- Investing in developing physician governance to ensure success.

How Do We Measure Up?

- In what ways do our physician organization and its governance contribute the greatest value to patients and other stakeholders?
- How might governance of this organization create barriers to success?
- What can we do to move governance to the next level?

Next Steps

Despite the range of variation among study participants in organizational size, structure, governance and other characteristics, panelists identified a number of key study findings that can have implications for all physician organizations and their governance:

- A strong, consistent governance and leadership focus on doing what’s best for patients and communities is positioning physician organizations as significant drivers of improved quality and financial performance and as architects of the new care delivery system.
- Governance practices are evolving to meet the needs of physician organizations at different points in their development.
- While comparing governance of physician organizations with that of hospitals and health systems can be useful, the evolution of physician organizations may indicate the need for variation in governance practices from those considered most appropriate for today’s hospitals and health systems.
- A physician culture that emphasizes inquisitiveness and the importance of understanding underlying causes for performance and outcomes supports good governance in physician organizations.

Sidebar

How Governance Can Impede Success

Governance can add value and create barriers to organizational success. Doing nothing, not engaging in crucial conversations, being perceived as self-serving and failing to base decisions on data and evidence are some ways study participants say governance can impede success.

*“We all know that **doing nothing** is a strategy, just not a very good one. That’s the biggest risk.”*

*“We want to **keep everybody happy**—it can be paralyzing.”*

*“**Failure to have crucial conversations** at the board-level—not dealing with nonperforming board members, not evaluating board member performance and providing feedback, not making improvements in governance.”*

*“Physicians on boards can get into big trouble if they come across as **self-serving**.”*

*“Physicians, and CEOs, can really shut down a conversation with lay board members when they **rely too much on their expertise and become overbearing**.”*

*“When physician organization boards **avoid using data and evidence** as the basis for dialogue and conclusions they risk making their interactions ‘doctor-protection focused’ versus patient-focused.”*

*“Boards lose an opportunity to leverage value when they **don’t consider service on a physician organization board as a testing ground for service on other boards** in a system.”*

*“An **ineffective chair** can really shut down a board.”*

*“Health systems that **fail to hardwire a commitment to physician engagement into organizational management and governance structures** may end up just paying lip service to physician organizations and their boards, which weakens their effectiveness.”*

*“Boards are missing the ball if they **don’t elevate quality and safety to the highest levels** and ensure there is a board quality committee that integrates its work with the organization’s quality functions.”*

- Defining moments in physician organization governance and leadership have the power to move organizational performance to higher levels with broader impact.

Study participants recommend a number of steps that can assist boards of physician organizations to rise to the challenge of governing in transformational times. Opportunities for continued work include:

- Ongoing research to better understand physician organization governance and leadership and its role in a changing health care delivery system.
- Education to support effective physician participation in governance and leadership.
- Development of tools and resources to assist physician organization boards to strengthen and improve their governance and address governance practices gaps such as the need to:
 - understand the difference between governance and management, since physicians are involved at both levels in their organizations;
 - define relative roles, responsibilities and authorities among boards and management (such as who hires and fires the physician organization CEO);

- more rigorously use skill and behavioral competencies in board member selection, reappointment and succession;
- develop deeper infrastructure (committees, outsider board members) to power governance in younger physician organizations and better understand committee effectiveness, for example, in more mature organizations; and
- engage in more self-reflection on board capabilities to drive improved governance.
- Broad dissemination of study findings to engage the field in examining the governance roles physicians and physician organizations play and how to better support their success in governance and leadership.

As one panelist concludes, “Boards should recognize that this is a historic moment of change in health care. History is going to judge us by what we do now. It’s time for governance to rise to the challenge.”

Resources

American Hospital Association’s Center for Healthcare Governance. 2009. *Competency-Based Governance: A Foundation for Board and Organizational Effectiveness*. Chicago, IL.

American Hospital Association’s Center for Healthcare Governance. 2010. *Competency-Based Governance Toolkit*. Chicago, IL.

American Hospital Association’s Center for Healthcare Governance. 2012. *Governance Practices in an Era of Health Care Transformation*. Chicago, IL.

American Hospital Association’s Center for Healthcare Governance. 2013. *Governance Tools for Transformation*. Chicago, IL.

American Hospital Association’s Physician Leadership Forum. 2014. *Physician Leadership Education*. Chicago, IL.

American Medical Association and American Hospital Association. 2014. *Proceedings from the AMA/AHA Joint Leadership Conference on New Models of Care*. Chicago, IL.

Combes, J.R. and Arespacochaga, E., *Lifelong Learning Physician Competency Development*. American Hospital Association’s Physician Leadership Forum. Chicago, IL. June 2012.

Appendix: Study Organizations

Advocate Health Partners (dba Advocate Physician Partners—APP): APP is a clinically integrated, independently owned, not-for-profit, multispecialty physician organization of more than 5,150 doctors serving more than one million patients in the Chicago area and central Illinois. APP was formed as a care management collaboration (joint venture) with Advocate Health Care and is comprised of physicians from the Advocate Medical Group, Dreyer Medical Group and independent physicians that are part of the system's 10 PHOs.

Billings Clinic: The Billings Clinic is a not-for-profit, community governed health care organization structured as a medical foundation. It consists of a 259-member, multispecialty physician group practice; a 285-bed hospital; a 90-bed skilled nursing and assisted living facility; and a research center. It serves approximately 148,000 people in rural Montana, northern Wyoming and the western Dakotas and is affiliated with critical access hospitals to deliver care across the region. Billings Clinic is a member of the Mayo Clinic Care Network.

East Bay Physicians Medical Group: A 230-member, for-profit, physician-owned multispecialty medical group established in 2005 that operates through an exclusive professional services agreement with not-for-profit Sutter East Bay Medical Foundation, part of Sutter Health. EBPMG serves 120,000 patients in Northern California.

Hill Physicians Medical Group: An independently owned, for-profit, multispecialty independent practice association operating for more than 30 years, Hill Physicians Medical Group encompasses more than 3,000 independent physicians serving 300,000 patients in Northern California. The group has no employees and is managed through a contract with PriMed Management Consulting Services—a management services organization owned by PriMed Management, Hill Physicians and Dignity Health.

Hospital Sisters Health System (HSHS) Medical Group, Inc. and HSHS Wisconsin Medical Group, Inc.: A not-for-profit, 160-member, multi-specialty group practice, this organization is an affiliate of the Hospital Sisters Health System supporting the interests and purposes of the Congregation of the Hospital Sisters of the Third Order Regular of St. Francis and commonly controlled with the hospitals sponsored by the Congregation. In its fifth year of operation, the group serves 376,300 patients in central and southern Illinois and Wisconsin.

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

BOARD PROFILE

Legal Name	Number of board members	Board composition	Board officer term length	# of terms for board officers	Board member term length	# of terms for board members	How often does the board meet?
Advocate Health Partners (dba/Advocate Physician Partners)	25	Representational and competency-based	Chair, chair-elect and committee chairs: 2 years	1	3 years	3	Every other month
Billings Clinic	12	Representational and competency-based	Chair: 2 years Vice chair: 2 years Secretary: 1 year Treasurer: 1 year	Unlimited number of terms	3 years	3	Monthly
East Bay Physicians Medical Group, Inc.	10	Representational and competency-based	Chair, vice chair, secretary, treasurer, committee chairs: 1 year	Unlimited number of terms	3 years	No term limits	Monthly
Hill Physicians Medical Group	12	Representational and competency-based	Chair, vice chair, secretary, treasurer, committee chairs: 1 year	Unlimited number of terms	3 years	No term limits	Quarterly, plus monthly Executive Committee meetings
HSHS Medical Group, Inc. HSHS Wisconsin Medical Group, Inc.	7	Representational	Chair, vice chair, secretary: 1 year	Unlimited number of terms	3 years	3	Quarterly
MHMD, Memorial Hermann Physician Network	23	Representational and competency-based	Chair, vice chair, secretary, treasurer: 3 years	1	3 years	3	6 times a year

BOARD PROFILE *(continued)*

Legal Name	Board activities	# of board committees	Committee names/# members/# meetings per year	Conflict of interest is disclosed:
Advocate Health Partners (dba/Advocate Physician Partners)	Orientation; Education; Member evaluation; Meeting evaluation; Retreats; Leadership development and succession planning	8	Contract and Finance/20/12; Quality improvement, patient safety, clinical integration/20/12; Utilization Mgmt./14/12; Audit/3/2; Credentialing and peer review/15/12	Annually
Billings Clinic	Orientation; Education; Full board self-evaluation; Member evaluation; Leader evaluation; Meeting evaluation; Committee meeting evaluation; Retreats; Leadership development and succession planning	7	Executive/6/2; Governance & Nominating/6/4; Finance/9/12; Audit & Compliance/5/4; Physician Compensation/9/1; Investment/7/4; Quality & Patient Safety/8/12	Annually
East Bay Physicians Medical Group, Inc.	Orientation; Education; Full board self-evaluation; Member evaluation; Retreats; Leadership development and succession planning	5	Quality & Risk Management/16/12; Governance/6/10; Strategic Oversight/12/10; Finance/14/12; Compensation/14/12	Annually
Hill Physicians Medical Group	Orientation; Education	4	Finance/7/12; Membership/7/12; Quality Assurance & Peer Review/7/12; Provider IT/7/12	As needed
HSHS Medical Group, Inc. HSHS Wisconsin Medical Group, Inc.	Orientation; Leadership development and succession planning; All trustees also serve as board members of a local system hospital	1	Compensation/7/as needed	Annually
MHMD, Memorial Hermann Physician Network	Orientation; Education; Committee meeting evaluation; Retreats; Leadership development and succession planning	4	Clinical programs/ 600/~200; Finance/10/6; Credentials/20/15-20; Special Review/5-6/2-4	As needed

PHYSICIAN ORGANIZATION PROFILE

Legal Name	Ownership/ control	Tax Status	Service Area	# of MDs	Single/ multi-specialty	# of patients served	Contract types
Advocate Health Partners (dba/Advocate Physician Partners)	Independently owned by shareholders or partners	Not-for-Profit (NFP)	Chicago/suburbs, central Illinois	5,150	Multi-specialty	One million	Shared savings, global and partial capitation, clinically integrated fee-for-service
Billings Clinic	Independently owned by shareholders or partners	NFP	Montana, Wyoming & the western Dakotas	259	Multi-specialty	148,000	Commercial, employer, Medicare, Medicaid
East Bay Physicians Medical Group, Inc.	Independently owned by shareholders or partners	For-profit	San Francisco Bay Area	230	Multi-specialty	120,000	Commercial, all government payers
Hill Physicians Medical Group	Independently owned by shareholders or partners	For-profit	Northern California	3,000	Multi-specialty	300,000	10 payer contracts to serve HMO members, all major California plans
HSHS Medical Group, Inc. HSHS Wisconsin Medical Group, Inc.	Owned and controlled by another organization	NFP	Wisconsin and Central and Southern Illinois	160	Multi-specialty	376,300	Commercial, Medicare, Medicaid
MHMD, Memorial Hermann Physician Network	Owned and controlled by another organization	For-profit	Greater Houston area	3,000	Multi-specialty	350,000	"Many"

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