Employed Physician Governance:

A Strategic Opportunity for Health Systems

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About the Author

Kimberly A. Russel, FACHE, is CEO of Russel Advisors and an advisor to The Governance Institute. Kim has over 40 years of healthcare executive experience including 25 years as a CEO. Kim's proudest career achievement has been her service as President and CEO of two distinctively different organizations: Mary Greeley Medical Center of Ames, Iowa (1995–2008) and Bryan Health of Lincoln, Nebraska (2008–2020). Kim recently retired from Bryan Health and formed Russel Advisors, a boutique consulting firm dedicated to helping healthcare boards and CEOs thrive amidst the chaotic healthcare environment.

Throughout her career, Kim has been an active member of over 20 boards and has served as chair of 10 boards. Kim holds a bachelor of science in management from Purdue University and a Master of health administration from Washington University.

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The Governance Institute

The Governance Institute provides trusted, independent information, tools, and resources to board members, healthcare executives, and physician leaders in support of their efforts to lead and govern their organizations.

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Table of Contents

Introduction

"My health system needs help improving the governance of our owned physician practices."

"The board that has been governing our employed physicians is not effective; we need to go back to the beginning and start over."

"There are MANY areas of improvement needed in our physician governance structure."

"Our employed physician group has outgrown its traditional physician leadership committee structure."

The above comments from four health system CEOs sparked the idea for this research project sponsored by The Governance Institute. The research purposes include:

1. To identify governance recommended practices for health systems that directly employ physicians.
2. To offer insights and considerations for health systems that are initiating or reimagining employed physician governance strategies.

Strengthening governance of the employed physician group is foundational to advance the health system's mission and related goals. Employed physicians are providing a greater share of medical services at hospitals and health systems so it is essential for this key physician group to be a full, collaborative partner with the health system. Employed physician groups with a mature governance structure are well-positioned to develop and execute the health system's strategies such as care improvement, clinical integration, shifting to value-based care, improving access, and more. Establishing an effective governance structure for the employed medical group is one indicator of the value the health system places on its employed physicians.

The research methodology involved an analysis of existing literature (see Additional Resources) and a series of personal interviews with health system CEOs and physician leaders.

Employed Physician Governance

The Situation

Direct employment of physicians by health systems has become routine over the past two decades. The American Medical Association reports that about 40 percent of all practicing physicians worked directly for a hospital or for a practice at least partially owned by a hospital or health system as of 2020.[1] The Physicians Advocacy Institute reports that over 341,200 physicians are employed by hospitals and health systems as of January 2022.[2]

For most health systems, physician talent acquisition has been an opportunistic strategy—resulting in a collection of different physicians, practices, medical specialties, and clinics, cobbled together over time. In many cases, governance of the physician practice enterprise has followed a similar patchwork pattern. Although the physicians may be linked by a common practice name and the same electronic health record, many health system-owned physician groups have not yet developed a true group practice environment or a common internal culture.

A nearly universal concern of health system CEOs, especially in the post-pandemic era, relates to a sense of disengagement by employed physicians.[3] Employed physicians exhibit disengagement in many ways, including an absence of collaboration toward achievement of health system goals and strategies.

With this history, it is not surprising that CEOs are realizing that the employed physician group is not meeting the growing needs and expectations of their health systems. Simultaneously, CEOs are concluding that a more effective employed physician governance strategy is paramount to improving the performance and strategic collaboration of the health system's employed physicians.

A Strategic Opportunity for Health Systems

With this backdrop, The Governance Institute believes that some health systems are well-positioned to implement a board structure with the responsibility of governing the employed physician group. For these health systems, implementing a board-based governance structure should be regarded as a strategic opportunity of mutual benefit to the employed physicians and to the health system. The Governance Institute recognizes that this is not a one-size-fits-all strategy. There are other effective governance models for employed physicians (see discussion below) and each health system's situation is unique. For some health systems, a board governance model is not currently (and may never be) a fit. However, for health systems

1 Carol K. Kane, Ph.D., *Recent Changes in Physician Practice Arrangements: Private Practice Dropped to Less Than 50 Percent of Physicians in 2020*, Policy Research Perspectives, American Medical Association, May 2021.

2 *COVID-19's Impact on Acquisitions of Physician Practices and Physician Employment*, 2019–2021, Physicians Advocacy Institute and Avalere Health, April 2022.

3 Disengagement is most certainly a challenge for other physician practice arrangements (contracted physicians, private practice physicians) in addition to health system employed physicians. However, the scope of this research is limited to health system employed physicians.

with both the interest and ability to effectively plan and execute such a strategy, a significant opportunity exists.

A Variety of Governance Structures

Our research did not uncover a "typical" governance structure for employed physician groups. Instead, it revealed tremendous variability across health systems in all elements of governance structure and composition, processes, and authority levels. Just as each health system is one-of-a-kind, so are the governance arrangements for the health system's employed physicians.

In general, there are three primary physician governance models:

- **No designated governance structure:** Health systems with a relatively small number of employed physicians often forgo a board or governance structure. Leadership is provided by a designated administrative executive or a physician executive (or both).
- **Council or committee:** This model is generally advisory only, although some health systems do provide limited authority for designated matters.
- **Board:** The employed physician governing board is established as a subsidiary to the parent health system board. The parent health system board maintains designated reserved powers. Authority levels provided to the subsidiary board vary greatly among health systems.

Of note, most health system CEO study participants—representing all models above—commented that their physician governance models are a "work in progress" and "in need of improvement."

Health System Aspirations for Governance of Employed Physicians

Effective governance for employed physicians is notably complex and presents numerous strategic and execution challenges. Health systems that are reengineering the employed physician governance model are striving to achieve these common goals:

- A high level of engagement and collaboration between the employed physician group and the health system.
- Agreement among the physician group, the health system board, and the CEO on the health system's key goals and priorities including the goals and needed contributions of the employed physician group.
- Physician leadership that proactively assumes responsibility and accountability for the work of the employed physician enterprise, meeting or exceeding the health system's standards for professionalism, quality, and operational and financial results.

One health system CEO summarized the aspiration for the health system's employed physicians: "We need more owners and fewer renters."

Case Study: Methodist Physicians Clinic

"You can't govern physicians. They must govern themselves."

—Steve Goeser
CEO, Methodist Health System

Methodist Health System (MHS), headquartered in Omaha, Nebraska, has outpaced national peers in the development of its employed physician multi-specialty group practice, Methodist Physicians Clinic (MPC). With a complement of about 330 physicians, 120 advanced practice providers and 40 clinic locations, MPC is a wholly owned subsidiary of Methodist Health System. MPC offers primary, specialty and subspecialty medical care and urgent care. MPC's national leadership is demonstrated by its results:

- Physician job satisfaction: 96th percentile (13th consecutive year, American Medical Group Association satisfaction survey)
- Quality: Top 10 percent nationally (CMS HEDIS data)
- Patient experience: 97th percentile (rating of provider)
- Administrative costs below the 10th percentile: Medical Group Management Association Cost Survey
- New patients: 11.5 percent increase (2021–2022)
- Urgent care total visits: 41 percent increase (2021–2022)
- Physician productivity: 75–80 percent (eight consecutive years)

When Todd Grages, MPC's President and CEO, joined MPC 18 years ago, the situation was much different. Relationships between the employed physicians and clinic and hospital leadership were dysfunctional, with low levels of physician satisfaction. Grages cautions, "It took five years of hard work to turn this around."

The philosophy is that practicing physicians are MPC's leaders. This strategy begins with physician leadership and decision making at each clinic site and extends to the MPC governance level. MPC is built on a tenet of "one physician-one vote." Grages notes, "MPC physicians may not own the practice, but they think and act like they do!"

Steve Goeser joined MHS in 2004 and became President and CEO in 2018. Goeser has had a front row seat for MPC's evolution into a group practice. "The multi-specialty group practice culture has now become pervasive. It took five years to get the culture going in the right direction," Goeser says. Goeser's beliefs about the relationship between the health system and MPC are clear, "Treating physicians like employees is a bad idea. The biggest problems happen if we [administration] try to tell physicians what to do. We are successful because the physicians govern themselves."

MPC does not have a Chief Medical Officer position. Instead, decisions are made at each clinic level by the practicing physicians. Enterprise-wide coordination, decision making, and prioritizing occurs at the physician executive committee. Twelve physicians serve on this body with designated representation among specialists, primary care, and hospital-based physicians. Participation on the physician executive committee is highly desired by MPC's physicians. Physicians are elected by their peers to three-year terms in a competitive process. The practice also has a physician performance improvement committee with 30 physician members. This committee also receives strong interest in participation from physicians across the enterprise. The committee focuses its work on improving patient experience and patient access.

Governance is provided by the MPC board of directors. Five seats are held by external community board members selected by the health system board and three seats are held by physicians selected by the physician executive committee. The board is currently chaired by an external board member. Goeser and Grages are not board members but attend most board meetings. Board responsibilities include finance, quality, physician recruitment/retention, and growth. Physician compensation is managed through administrative (not governance) channels, with full transparency to the physicians.

There is close coordination and integration with the health system's strategic plan. In addition to regular reporting at meetings of the parent board, the MPC and MHS boards meet at least annually for an in-depth discussion of the strategic plan.

MPC's charge from the health system is, "To advance our ability to work as a health system, improving the care we provide, dominating the market, solidifying our reputation and creating sustainability of our hospitals' service lines." The collaborative relationship that has developed between MPC and its parent health system has resulted in a growing multi-specialty physician practice that continues to support and advance the growth and mission of Methodist Health System.

Elements of Effective Physician Enterprise Governance

Health system boards and CEOs contemplating a board-based governance model should consider these essential aspects of successful governance:

- **Physician involvement:** The health system board and CEO must regard the employed physicians as key partners and sincerely value in-depth involvement with these physicians. Developing a partnership with employed physicians is a deeper commitment than a simple employer to employee relationship; such a partnership must be a key business strategy of the health system.
- **Reserved powers:** The health system board must maintain certain reserved powers. In most cases, the reserved powers will be similar across all system subsidiaries, including the employed physician entity.
- **Board composition:** Board composition decisions for an employed physician entity governing body are critical and should be tied to the health system's longer-term physician strategies. (See discussion below.)
- **Authority and accountability:** The physician enterprise governing body must have clearly and specifically designated authority from the health system.

Without sufficient authority, accountability for results and outcomes is likely to remain low. (See discussion below.)

- **Physician Leadership:** Internal physician leadership is a "must have." Developing physician leaders usually requires an ongoing and long-term investment by the health system in leadership education and training for high-potential physicians.
- **Distinction from the medical executive committee (MEC):** Governance of the employed physician enterprise is distinctively different from the MEC function of the medical staff. The employed physician governing structure should avoid duplication of medical staff functions. It should also be noted that especially in larger health systems, the health system may have employed physicians on many different medical staffs across multiple geographies.
- **Governance support:** Physician enterprise board and committee meetings must be staffed with an appropriate level of administrative support. Similarly, physician enterprise board members should receive training and education about governance roles and responsibilities.

A more effective employed physician governance strategy is paramount to improving the performance and strategic collaboration of the health system's employed physicians.

Additional Key Decisions

As a health system is considering either strengthening an existing employed physician entity board or creating a new board, there are additional considerations and decision points:

Board Composition

Should the board be composed exclusively of employed physicians? Should the board include a combination of employed physicians and outside directors?

This research demonstrates that both all-physician boards and a broader board composed of physicians and outside directors can be successful. The model selected ultimately relates to the health system's culture and overall strategy.

Health systems with physician-only boards deem that this composition commands the most respect and credibility with the physicians. The expectation is that this board structure will be more effective in achieving a high level of buy-in and results from the employed physician group.

The primary reason a health system may opt for broader board composition is to bring non-medical expertise (business, corporate, financial) to the physician practice governing body. Including outside directors on the board may also guard against a natural tendency for physician-dominated boards to focus on operational matters. Caution: The outside directors must be carefully selected with clearly demonstrated

professional expertise. The idea is to rapidly develop mutual respect among the physician directors and non-physician directors.

Should the health system CEO participate on the board?
Should the top practice executive participate on the board?
Based on this research, health system CEO attendance and participation at board meetings (regardless of voting status) was an indicator of strong board performance. Health system CEO participation serves as a checkpoint to maintain common purpose and goals between the health system and employed physician enterprise. Typically, the top practice executive attends and participates at all board meetings, generally without holding a voting seat.

Should a board seat be reserved for an employed advanced practice provider?
Most health system research participants reported one board seat for an employed advanced practice provider. In many health systems, the number of employed advanced practice providers exceeds the number of employed physicians. Caution: An advanced practice provider serving on the governing body does not "represent" the advanced practice provider staff—just as an orthopedic surgeon serving on the governing body does not "represent" orthopedic surgeons. Like all boards, each director's duty is to the entity itself and to its mission. The point is to bring the advanced practice provider perspective and experience into the board's discussions and deliberations.

Board Authority and Accountability

To whom is the employed physician entity board accountable?
Formally, the employed physician board is a subsidiary board of the health system, thereby reporting directly to the health system board. There is often an additional matrix arrangement, in which board leadership collaborates closely with the health system CEO or another designated system executive.

What are the board's authorities and responsibilities?
The research demonstrates great variability in the establishment of authority levels for the employed physician board. For example, some boards have responsibility solely for the professional practices of the physicians. Other boards have expanded authority to include services such as the outpatient clinics and urgent care centers. The health system board generally establishes the overall budget and financial parameters, with the subsidiary physician entity board maintaining responsibility for financial results. Capital expenditures may have financial limits requiring additional system approval.

Most health system boards grant the health system CEO either the final decision-making authority or veto power over the selection of the top practice executive. The subsidiary employed physician board usually has full authority over quality. Physician recruitment is commonly the responsibility of the employed physician practice entity, although advance system approval may be required in some instances.

Among the most critical responsibilities of the employed physician entity board is developing a robust and effective internal culture among the physicians. The end

game is for the physicians to evolve toward a multi-specialty group practice culture that is knit together via collegiality and shared purpose.

Does the board have authority for physician compensation?

Health systems are understandably very careful in establishing compensation structures and approval processes that are compliant with the myriad of regulations and laws governing physician compensation. Some health systems delegate employed physician compensation exclusively to the health system board's compensation committee; with this arrangement, the employed physician entity board is not involved with physician compensation. In other approaches, the employed physician board's authority may extend to the recommendation level. With this arrangement, either the overall compensation framework and/or specific compensation packages are reviewed by the entity board and then forwarded with a recommendation for final action to the health system.

Responsibilities of the Employed Physician Board

As the employed physician board matures, the board will grow in depth and value to the health system. Agenda items will flow from the board's responsibilities:

- Establishing standards of medical care and professional conduct for the group.
- Quality, safety, patient experience, and patient access strategies, with responsibility for outcomes and results.
- Developing a multi-specialty group practice culture.
- Developing and executing growth strategies, including physician recruitment.
- Physician and advanced practice provider wellness strategies.
- Oversight of physician leadership development strategies.
- Ongoing board education with a focus on continuous governance improvement.

Avoidable Employed Physician Governance Missteps

Establishing an effective board structure for health system-employed physicians is a longer-term strategy that requires skilled execution. Health systems will stand a better chance to successfully deploy this strategy with the following guardrails:

- **Representational governance:** Directors serving on the employed physician board represent the entire organization, not a single constituency. This reality must be emphasized during board recruitment and new director orientation. It should also be reinforced periodically by board leadership during board discussions.
- **Board scope:** The health system board must clarify both verbally and in board documents the full scope of the employed physician governing body. In scope/out of scope decisions for the employed physician entity must be clarified up front.
- **Operational focus:** Establish a committee of physician leaders to handle operational issues. This will maintain the board's focus on strategic, enterprise-wide matters.
- **Board size:** A smaller board size of 8–10 is well-positioned for full engagement from all directors. The smaller size also ensures that each director's voice is

influential and not lost in a large chorus. Ultimately, physicians often place higher value on a smaller and more nimble board.

- **Strategy mismatch:** The health system board and CEO must completely buy into the strategy of physicians as partners with a shared investment in the health system's mission and success. This is a long-term strategy which must be an essential element of the health system's DNA. Absent this belief and commitment, a strategy mismatch will be quickly discerned by the physicians.

Recommended Governance Practices

For health systems that choose to adopt a physician entity governing board strategy, recommended steps forward are:

- Devote considerable time at the health system board level to discuss the meaning of employed physicians as full partners within the health system. What are the expected results from this strategy? What are the indicators of success?
- Board composition decisions are critical and highly strategic. Although some health systems have been successful with all-physician boards, the recommended practice is to include at least two to three external, independent directors. The board will benefit from a combination of medical and non-medical expertise. The external board members should be experienced and have a strategic mindset.
- Health system CEO participation on the board (either with or without a voting seat) is strongly encouraged. The CEO's involvement will also ensure calibration between the physician entity board and the parent board.
- The health system must invest in leadership and governance training for the board. For physician board members without previous governance experience, the learning curve may be surprisingly steep.
- The health system should delegate as much authority and responsibility as possible to the employed physician board.
- The board must receive appropriate administrative support resources.

Final Thoughts

This research revealed the struggles that many health systems are experiencing with their employed physician groups. The outside pressures on health systems and practicing physicians are relentless. The employed physician board is not a one-size-fits-all strategy; this strategy will not be effective for all health systems. However, for health systems that are seeking true integration and partnership with employed physicians, developing an "all in" governance model can advance the mission faster and farther while also bringing deeper engagement and a greater purpose for the physicians.

Additional Resources

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