Happy Together: Physician Governance in Group Practice

Sharing experiences

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Discussion Ground Rules

- Open panel lively discussion that are TIMED!
- Panelists will share their experiences but audience input will be short
- No real didactic slides.. just lots of questions or give and take
- Audience monologues will be discouraged
- Moderator has been empowered to interrupt panelists and audience to keep discussion moving

#1 Panelist Background (5 minutes)

- Jim Sussman
- Jason Biddy
- Marshall Grodofsky

Will focus on organizational structure of their practices (and past experience)

#2 How is compensation determined in your practices? (10 minutes)

- How do you determine how to divide revenues?
- Are all revenues treated the same? (immunotherapy treated differently from patient visits?)
- Do all physicians have equal access to all types of patients?
- Do you compensate for administrative work?
- Productivity calculations used?

#2 How is compensation determined in your practices? (5 minutes)

- How do you determine how to divide expenses?
- Fixed versus variable (related to hours working seeing patients)
- Do you treat expenses contracted by previous partners differently than for newer partners who didn't have a say?
- Productivity calculations? Personal business expenses?

#3 How does one become a leader in your practice? (5 minutes)

- Partnership: Buying–In
  - Money vs. sweat equity
  - Are there different levels of "partnership"?
- How is leadership decided?
  - Elected vs. appointed?
  - Term limits to leadership position?
- Are physician employees given a say?
- Office administrators "leadership" role?

#4 Organizational Meetings (10 minutes)

- What types of meetings do you have?
- How often do you meet?
- Who attends?
- How do you get everyone together?
- Decision making (how are they finalized?)
- Who moderates?
- Policing: Attendance & penalties for missing meetings; Do you distribute minutes?

#5 Meeting Topics (10 minutes)

- What are routine topics for meetings?
  - Staffing
  - Financing
  - Procedural issues
  - Practice development & marketing
  - Work hours
  - Business planning
  - Other?
- Specific topics:
  - Staff review and compensation
  - Future direction of the practice
  - Consistency in medical decision making
  - Consistency in medical procedures

Specific Topic:

- How do you come together on medical decision making and practice styles?
- How do you police these decisions?

#6 Policing Physicians (10 minutes)

- How do you address physician partner problematic behavior???
- What happens if you disagree? (how is conflict resolved?????)

#7 Handling a part time, "slowing down" or retiring physician; hiring a new physician

- Who makes the decision?
- Do you have a written policy in place to outline these circumstances?
- For newly hired physicians, do you have a mentorship program, organized regular feedback, expected production quotas that have to be met?

OTHER QUESTIONS??

- Audience feedback

MGMA Connection magazine, May 2015

Herding cats

By Will Latham, MBA, CPA, MGMA member
May 1, 2015
Body of Knowledge Domain(s): Organizational Governance

As medical groups deal with increasingly complex issues that come at a faster rate, professionals must adopt effective group governance as a survival skill. Unfortunately many medical groups are not able to effectively deal with important issues, such as how to grow the group, what new services to offer and how to develop affiliation partners, because the group has an ineffective governance system and what I call governance disorder syndrome (GDS).

What are the symptoms of GDS?

- Groups can't make timely decisions (or can't make decisions at all).
- Individual members of the group don't adhere or support group decisions.
- Group meetings are chaotic and ineffective.

Why is it so hard for medical groups to develop and use an effective system of governance? Two reasons I see repeatedly come from key organizational dynamics: conflict management and team development.

Conflict avoiders

The organizational dynamic that has the greatest effect on group governance is the way in which individuals approach conflict management in group settings. According to research conducted by Kenneth Thomas and Ralph Kilmann[1], people react to interpersonal conflict in one of five ways:

- Competing
- Collaborating
- Compromising
- Avoiding
- Accommodating

These five behaviors are arranged along a two-dimensional axis, from assertive to passive and from cooperative to uncooperative. Organizations frequently use the conflict mode instrument, introduced by Thomas and Kilmann in 1974, to assess the ways in which individuals handle

conflict. We have used this instrument to survey physicians and found that in physician-to-physician relations, 80% were conflict-avoiders.

While some physicians are adept at dealing with conflict (and may actually enjoy it), most avoid it. If you are an experienced medical group manager or leader, you have probably witnessed the following situations:

Doctor A comes to your office and complains about Doctor B. Thirty minutes later, Doctor B comes in and complains about Doctor A.

You have “after-the-meeting” meetings when individuals complain that certain issues were not raised or discussed at the meeting.

Individuals display passive-aggressive behavior such as agreeing to a decision in a meeting and then not supporting the decision after the meeting.

If some physicians are reticent to speak up (because they are conflict-avoiders), you will need a system of governance in which group physicians believe the rules are fair and that their voices can be heard.

Stages of group development

Another important organizational dynamic in medical groups relates to a key theory known as the four stages of team development, which outlines the ways in which teams develop with time. Under this concept, all groups or teams go through the following identifiable stages that affect their performance as a group:

Forming. Groups enter this stage when they start to work together. Team members are often positive and polite, and go out of their way to avoid conflict.

Storming. Once a group has worked together for a while, conflict emerges as people start to push against boundaries established in the forming stage. Authority is challenged and people jockey for position.

Norming. As group members work to resolve their differences, the group establishes “norms” — standards of behavior that group members develop to guide interactions between group members.

Performing. In this stage, there is less friction in the group, and group members have learned to act as a team. They agree on goals, roles and norms, and members are aligned toward producing results.

Unfortunately many medical groups get stuck in the storming phase, with lots of conflict and hostility, because group members aren’t willing to take the necessary steps to move on to the norming stage. To get to the next stage, they need to establish group norms for:

- Resolving conflict
- Making decisions
- Communicating with others

- Completing assignments
- Managing meetings

These norms are all part of an effective system of governance.

Overcoming GDS

Here are four steps you can take to overcome GDS.

Step 1: Agree on a decision-making process. Many medical groups, large and small, suffer from something we call the “dirty little secret,” which goes something like this: A physician thinks, “If I don’t like a group decision or I didn’t vote for the decision, I don’t have to abide by it or support it.”

Of course, no one really comes right out and says this, but that is often the way individual physicians act, which can hurt a group. To prevent this reaction, I recommend asking and answering these three fundamental questions:

- **How does our group make decisions?** Group members need to agree on a fair and reasonable process to discuss issues and make decisions. As a group considers an issue, there should be some discussion and a vote. Many groups agree to empower a subset of the physicians (such as a board) to make certain decisions for the entire group. We think it is unreasonable to require unanimity on decisions, and you must be very careful in pursuing consensus, which most people take to mean unanimity. In today’s environment, a medical group needs to be able to move forward with a majority or supermajority vote. (A majority issue requires a vote of greater than 50% to act; a supermajority issue requires a voting level higher than a majority vote, such as two-thirds, to act.)
- **What is expected of each physician once a decision is made?** Group members must agree to:
  - Execute the decision
  - Abide by it
  - Implement it
  - Support it
  - Not sabotage it
  - Not complain about it to outsiders

Overcoming GDS will be nearly impossible if group members don't agree that these expectations apply to each and every physician for all group decisions.

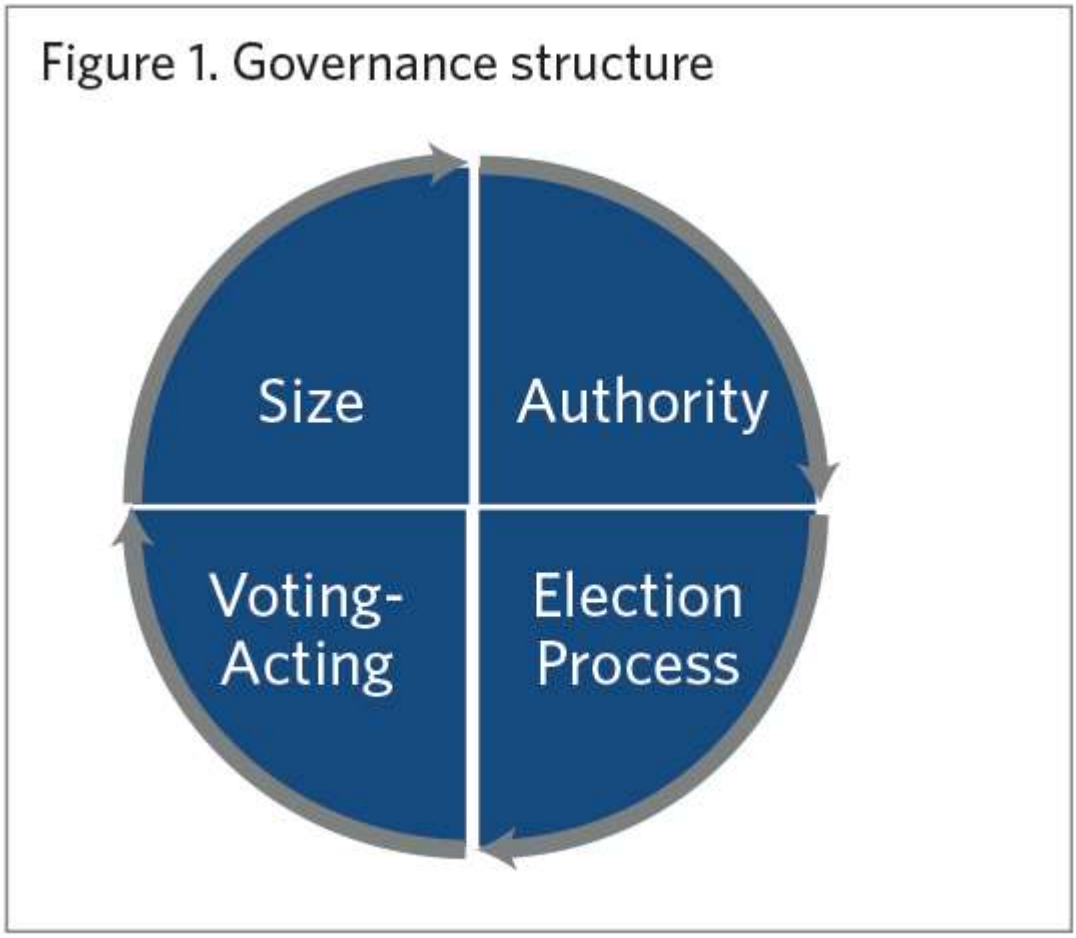
- **What are a physician's options if he or she doesn't like a decision?** There are three:
  - Do it anyway. If you want to be in group practice, there will be times when you must support something you may not fully agree with.
  - Try to get the decision changed in the right forum (i.e., the shareholder or board meeting), and continue to abide by the decision until it is changed.
  - Leave the practice. Clearly this is a tough one, but each physician should commit to either supporting group decisions or leaving the group. Set the expectation that a physician will not and should not stay with the group if he or she will not abide by group decisions.

Several years ago, I kicked off a strategic planning retreat by asking the members of a medical group these three fundamental questions. After the members agreed on the method they would use to make decisions — that individuals were expected to support all group decisions — one of the physician said to me, "So let me get this straight: In today's meeting, we are going to make some decisions?"
"Yes," I replied.
"And we are really going to implement the decisions we make?" he asked.
"You just committed to do so," I said.
"Well," he said, "I guess I am going to have to pay a lot more attention today than I have at any other planning retreat I've attended!"
This was a very telling comment. Before agreeing to these questions, he knew there was no real commitment or expectation that individuals would implement decisions because the group had never agreed that it would.
The answers to these questions form the basis of developing any effective system of group governance.
Step 2: Develop a vision statement. Some readers' gag reflex will kick in when they hear the need for a vision statement because they have spent entire weekends in other healthcare organizations planning and devising statements such as "our vision is to serve patients well" or some over-the-top flowery statement. I don't support "kumbaya" or "examine your navel" processes. Instead, I believe vision statements serve a clear and critical role for two reasons:

- Highly successful medical groups share one thing in common: a clear, specific, coherent and empowering vision. The reason is simple: No organization can accomplish what it is unable or unwilling to imagine.
- You can't pursue 15 (or however many physicians there are in your group) visions. There are not enough resources.

Remember, the difference between a vision and a hallucination is the number of people who see it. Developing a vision statement should be a group endeavor. In my experience, the best way to get started is to pose a set of questions to physicians at a planning retreat. The sidebar (below) has a list of recommended questions to help your group get started.

Step 3: Develop an effective governance structure. An effective governance structure considers four major areas: size, authority, election process and voting-acting (Figure 1).



First, the group needs to decide on the structure of its governing board: how many people will be on the board and whether various specialties, areas or departments will be represented (Figure 2).

Figure 2. Size of governing board

1. How big should the board be?
2. Should it be representative?
   a. Division
   b. Location
   c. Age
   d. Other

Delineating authority of the governing board is also critical (Figure 3). How much can the board spend without coming back to the entire group?

Figure 3. Authority of governing board

1. What should be the authority of the board?
2. What should be reserved for the shareholders?

For voting-acting, group members need to agree on additional parameters (Figure 4), for example, which items will require supermajority, whether or not proxies are allowed and how issues can be re-addressed. Who can the board hire and fire? What contracts can the board sign?

Figure 4. Voting-acting

1. How often will the board meet?
2. How many votes of the board should be required to act?
   a. Are there any supermajority items?
   b. If an item does not pass, what happens? (Does it go to the shareholders?)
3. What will be the quorum?
4. Will proxies be allowed? If so, what type?
5. If the board makes a decision within its level of authority, can such a decision be overturned? If so, what is required to raise the issue for discussion and to overturn it?

Some groups overlook the importance of the election process. But if members believe the election process is tainted, their view of the entire governance system alters. Key components of this process are given in Figure 5, including whether the group should agree on the timing of elections and the election process, whether terms should be staggered and whether there should be term limits.

Figure 5. Election process

1. How should the board be elected?
2. Election process:
   a. Who is eligible?
   b. Secret ballot?
   c. Timing?
3. What is the term duration? Should terms be staggered?
4. Should there be term limits to the number of terms served?

Step 4: Make meetings work. No matter your group's size or specialty, meetings are a tool that all groups use in their governance processes. Much of the work of governance is done in group meetings. While there is a lot of background work completed outside of meetings, the real discussions, debate and decision-making typically take place during group meetings.
Chaotic and unproductive meetings can be a sign of governance problems: The wrong issues are discussed, reasonable conclusions are not reached, and decisions are not made. One way to improve the effectiveness of your group meetings is to create and use meeting ground rules. Think about your most recent group meeting and ask yourself:

- Were many people talking at the same time?

- Were there multiple sidebar discussions (talking to the person next to him or her, or texting)?
- Did the discussions veer way off topic?
- Did some participate in the discussions while others didn't?
- Did telephone calls interrupt the meeting?
- Did participants arrive late or leave early?

Ground rules are the observable behaviors that group members agree are expected from everyone attending the meeting. Ground rules should focus on observable behaviors. You might run into trouble with a ground rule that requires everyone to be open-minded because that is subjective — it happens inside someone's brain and cannot be an undisputable, observable behavior. It's best to set ground rules as a group process, developing them together rather than in isolation. Individuals are more likely to adhere to ground rules if they help develop them. To start this process, ask attendees to define what observable behaviors should be expected of each member. Responses should cover the following key ground rules:

- Let the other person finish talking before you begin talking.
- Address the group and eliminate sidebar discussions (oral or text).
- Keep the conversation on topic.
- Ensure everyone at the meeting contributes to the discussion.
- Deal with telephone calls outside the room so work can continue.
- Respect start and finish time.
- Keep the discussion confidential unless members specifically agree otherwise.

Once the ground rules are established, distribute them to the group and review the rules at the beginning of every meeting. Most groups find that group meeting performance will improve by verbalizing ground rules, which assume more importance when they are modeled by the person who manages the group meeting.

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Notes

1. Thomas KW, Kilmann RH. Thomas-Kilmann Conflict Mode Instrument, 1972 and 2002. Xicom Incorporated, 2002: 7.

Vision statement questions

Looking out three to five years:

- What is your preferred future? What does the group intend to become?
- What services and specialties do you plan to offer?
- What geographic region do you intend to serve?
- How many locations are you likely to have?
- How big will the group become? Will you grow to fill the service needs of the market or will you set an upper
- end limit on the number of physicians in the group?
- What type of relations will you have with others?
- Will you remain an independent group?
- What benefits do you hope to provide for the owners and employees?

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- See more at: http://www.mgma.com/practice-resources/mgma-connection-plus/mgma-connection/2015/may-2015/herding-cats#sthash.42IrwYI0.dpuf