Special Report

Effective Governance:

The Time Is Now!

Latham
Consulting Group

Make Decisions, Resolve Conflict, Move Forward

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Changing Times

"Most of us have big trouble rejecting or seeing the need to move beyond a technique or strategy that worked well in the past."

From "Why Companies Fail" in *Fortune*, November 14, 1994

The changes taking place in healthcare are dramatic: increasing levels of managed care, reduced reimbursement, integration of providers. All specialties are affected and are especially vulnerable to many of the changes now underway. The trends are enormous in their impact, and irreversible:

1. ***Managed care:*** As managed care takes hold, the number of physicians needed to service a given population is going down for most specialties. Patient populations shift, pressure on reimbursement is increased, complexity rises.
2. ***Consolidation - Relationships with hospital(s):*** Many groups are being pressured by the hospitals in which they practice to become employees as opposed to independent physician organizations.
3. ***Increased Risk:*** With the many changes taking place, there is increased risk in each decision the group must make, and the added risk caused by delaying decisions. Successful groups will act quickly on opportunities. "Also ran" groups will not.

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Unfortunately, dealing with these external and internal challenges is made even more difficult by the following:

- For most medical groups, the governance/management structure is often ineffective.
- This results in a limited ability to make decisions.
- Most groups haven't made long-range plans for their organization.
- With no plans in place, it is difficult for management to do an effective job of implementation.

Even with these weaknesses, up to now most groups have been quite successful in meeting the personal needs of the physicians. Most physicians have been reasonably well compensated and have had a significant level of independence. Because of this success, many physicians are subject to the quote opening this Special Report - "Most of us have big trouble rejecting or seeing the need to move beyond a technique or strategy that worked well in the past." These physicians have been lulled into thinking that what has worked to make them successful in the past is all they need to be successful in the future.

But we are now seeing fundamental changes and those groups that continue to have weak governance/management structures and who do not develop long range plans will be remembered as having spent their time "re-arranging the deck chairs on the Titanic."

This Special Report will focus upon how medical groups can improve their prospects for being successful in the future through ORGANIZING (improving their governance and management structure), PLANNING (developing implementable long-range plans for their groups), and taking ACTION.

ORGANIZE – Practice Governance Structure

Governance is the set of rules and structures, established by the group, that guide the group and its members on doing business with each other and external parties. Typically these issues are addressed in the group's

organizational documents, such as the group's bylaws, or in other written documents which outline the "rules of the game."

Weak governance hurts a practice in many ways: needed decisions are delayed, bitter and personal disagreements erupt, no planning is done, all actions are reactive instead of proactive.

The first step in creating an effective structure is to define how many people need to be involved in making decisions, and what decision-making structure you need to be effective.

The objective of a tiered governance structure is to have the "right" number of people involved in making decisions. Typically, "right" can be translated as "the fewer, the better" (up to a point). The more people involved in any decision, the longer it takes to make it and the more risk you have of "lock-up." Accordingly, it is very important to specify both the responsibility of each part of your governance structure (what you expect them to do), and the authority of that part (how much latitude you allow them). Allocating responsibility without commiserate authority is a recipe for failure.

While it is difficult to generalize (because of the vast range in sizes of medical groups), the functions of each of these parts of the governance structure is as follows:

Shareholders/Partners

The owners of the practice (shareholders or partners, depending on the legal organization of the practice) are typically all active physicians who are fully invested into the practice. Typically, all physicians have an equal vote at this level (groups which allow some physicians to have greater voting power than others because of seniority or differing levels of investment often encounter significant problems in implementing decisions).

Although any and all decisions should ultimately be ratified by the owners, it makes sense to limit discussion among this larger group to only the most significant issues facing the group. In many practices, such items are limited to issues such as adding or expelling physicians, major changes to the income distribution system, or other issues of such magnitude.

Typically the entire ownership group meets quarterly or biannually (or in a called session) to discuss only the major issues facing the group.

For smaller groups (less than five physicians), this may be the only part of the governance structure needed (other than electing a President and hiring management). As groups grow larger, they may need to implement a Board of Directors and/or an Executive Committee.

Board of Directors

In larger groups, the ability to include all physicians in every decision becomes cumbersome. Over and over again we have heard physicians complain about "never-ending" shareholder meetings at which little was accomplished!

Groups with effective governance structures typically elect a Board which serves to make decisions for the group on a week-to-week basis. Depending on the size of the group and the other governing bodies the group has in place, the Board's size may range from three to nine. The Board should always include an odd number of physicians to avoid ties when voting.

As mentioned earlier, the group needs to be careful to set out the responsibilities of the Board, as well as its authority. Authority tends to revolve around what the governing body can do in terms of:

- Hiring and firing (both on the clinical and administrative sides),
- Spending, and
- The ability to enter into contracts and relationships.

(We have seen instances were groups have established Boards who are authorized to make all the decisions for the group. The other physicians agree to live by their decisions, but have the right to vote them out of office every one to two years if they are not satisfied with their efforts. While such a system is best in terms of its ability to make decision quickly, few physicians are currently willing to place such authority in the hands of a smaller group.)

It is important to note that it does little good to set the system up where all issues discussed and voted on by the Board must be re-visited by the Shareholders. Therefore, groups that establish such a system typically provide a report to the shareholders on the activities of the Board, but items acted upon are not brought up for further discussion at the Shareholder meetings.

Typically, the Board is also charged with the responsibility of developing and monitoring implementation of a long-range plan for the group.

Depending on needs of the group, the Board meets monthly or quarterly.

Exhibit 1 (below) shows an example Charter for a Board for a 10 member group. In this example, all physicians serve on the Board.

For some groups, the ability to have all the members of the Board meet to provide oversight on a week-to-week basis is not possible. These groups often elect a smaller body, the Executive Committee, to meet on a more frequent basis.

Executive Committee

Once again, the goal in establishing an Executive Committee is to empower a smaller group of physicians to take actions on operating issues facing the practice. Executive Committees typically have 3 to 5 members, and focus on the day-to-day issues.

Depending on the needs of the group, the Executive Committee may meet weekly or monthly.

Exhibit 2 (below) shows an example Charter for an Executive Committee.

President

Irrespective of what other parts of the governance structure the group has in place, most groups elect a President whose primary role is to lead the organization. It is important to elect someone who will provide that leadership function. Unfortunately, many groups elect physicians who are considered the "nicest," least controversial and/or those who seek to make everyone happy.

In the new environment, this can be a mistake. Today, groups need strong leaders who are willing to make or push for the hard decisions which insure the survival of the group.

The President of the group also works closely with the group's management to ensure that the organization operates effectively. *Exhibit 3* (below) shows an example of a job description for a group's President.

Management

Management is the final link in the governance/management chain. Once again, specific responsibilities and authority must be outlined for this position.

Exhibit 4 (below) provides and example job description for the Administrator of a medical group.

What Does Your Group Need?

Depending on the size of your group, you may not need all of the elements discussed above. In smaller groups some functions can be combined and others eliminated. The following chart provides some suggestions:

Function	***1-10***	***11-20***	***>20***
Shareholders	All owners.	All owners.	All owners.
Board	All owners.	3-5 owners.	7-9 owners.
Executive Committee	All owners.	Combined into Board.	3-5 owners.
President	One, elected.	One, elected.	One, elected.
Management	Non-physician Administrator	Non-physician Administrator	Non-physician Administrator

PLANNING - Setting Long-Range Plans

Once the group has established an effective system of governance, it needs to decide where it wants to go and how it plans to get there.

Although group medical practice offers a number of significant benefits, it also has its share of frustration and risk. Oftentimes, much of the frustration of

group practice springs from a lack of common goals for where the practice is going and how it should get there. The source of this problem is often a lack of communication between the physicians about the important issues facing the group.

This lack of communication also increases risk to the practice. If the physicians in the group have trouble making decisions or do not discuss the direction they are heading, it is often impossible to implement programs to avoid threats, fix weaknesses, and pursue opportunities.

Upon reflection, many physicians discover:

1. They do not know where the practice is heading, let alone how it plans to get there. Normally, the group focuses only on near-term decisions required to continue basic, day-to-day operations.
2. That the world of healthcare is changing dramatically, and that the practice might not be prepared to deal with changes such as tighter regulations, higher consumer expectations, increasing competition, and shrinking reimbursement dollars.
3. Finally, they realize that their personal success is heavily tied to the success of the group. The individual physician normally has a significant investment in the group in terms of reputation, time, effort and money.

Why do physicians resist meeting and planning for the long-term success of their organization? Studies have shown that, by their training and personality, physicians are generally independent decision makers. In addition, most physicians would rather focus on the art of their profession, instead of the business of their practice.

But with the dramatic changes that are taking place, the successful practice recognizes the need for a group discussion of the future direction of the organization. One of the most effective ways to accomplish that is through strategic planning.

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Strategic Planning

Many groups are now using a well-known business process called strategic planning to help them set the future direction of their practice.

Strategic planning is a buzzword for a relatively straightforward process of defining the purpose of the group (why it exists), setting objectives (where it wants to go), and mapping a plan to meet those objectives (how it plans to get there).

The process involves 5 major steps:

1. Reviewing the major trends in the national and local environment to identify opportunities to be pursued and threats to be avoided.
2. Analyzing the practice itself to identify weaknesses that need to be corrected, and strengths of the practice that can be used to enhance its position.
3. Defining the purpose of the practice by establishing a mission statement for the group. The mission statement outlines the central vision and focus of the group practice.
4. Developing a prioritized list of objectives for the practice to pursue for the next several years.
5. Developing strategies to achieve the objectives through preparing action plans, making decisions or setting policy.

What does the strategic planning process look like in the real world? Basically, it's series of discussions and decisions among the physicians and practice management about what is truly important for the practice. It often involves data-gathering and analysis to support these discussions, and many groups utilize a planning retreat process as part of the plans development. Such a retreat can also be an effective forum to decide on and implement a governance structure.

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The Payoff

The time devoted to this process can result in tremendous benefits for the group. Organizations who have developed a strategic plan for their practice point to:

- A decrease in the frustration of group practice as physician needs are identified and acted upon.
- Improved performance as the staff has an agreed upon guide of objectives to pursue.
- Better utilization of resources to meet the expressed needs of the group.

The success of medical groups often hinge on forming a unified view of where the group is heading, and mapping an agreed upon course to reach that future. Strategic planning can help your practice reach its intended future.

Getting Started

One way to kick-off the planning process is to survey the physicians to determine their current satisfaction with practice operations and their long-range objectives.

Groups who conduct such a survey often realize:

- They haven't thought about many of the important issues facing the group; and/or
- There is a significant diversity in goals for the group as well as the degree of satisfaction with group operations.

If either or both of these conditions exist, it is up to the leadership of the group to promote a strategic planning effort for the group.

Conclusion

Developing an effective governance structure and creating a long-range plan for the group puts the group in the position where it can take actions in a coherent manner. It will be up to the leaders of the group to keep the group moving in the direction outlined in its plans and endorsed by the governance structure.

Insanity has been defined as "doing the same thing and expecting different results." If your group hopes to survive and thrive in the future, it's time to ORGANIZE, PLAN and ACT.

Addendum

In our consulting assignments, we have been asked a number of questions about how to improve the effectiveness of a group's governance system. Following are several questions as well as ideas for solutions:

"We have created an Executive Committee of three physicians and given them significant authority. However, they will not make decisions within the bounds of their authority because they are afraid of second guessing by the other physicians. What can we do?"

There's no doubt about it, serving as a leader in a physician group is a tough job. Decisions will be second-guessed, and some people will not like any decision that is made. Here are a couple of suggestions:

1. First, the leadership must recognize that criticism comes with the job - if they can't take it or expect it not to exist, they should avoid serving as a leader.

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2. The leadership must help each other develop the mind set that it is their job to make these tough decisions, and then stick up for each other in front of the larger group.
3. If the larger group continually second guesses the authority of the leadership, the group at large should re-discuss what level of authority they are truly willing to give the leadership.
4. In some cases, leaders are afraid to make decisions because any decision can be recalled to the larger group for another vote by the members at large. Naturally, this defeats the purpose of a governance structure. For group's with this problem, they should consider a provision that requires a 2/3 majority of the partners to even bring up for discussion an issue decided within the authority of the leadership.

"It seems that we make a decision, and then continually re-visit it over and over again. How can we avoid this?"

This is a challenge for almost every group. It is typically caused by those who did not get their way in the first vote and is often used as a strategy to paralyze the group.

When physicians raise their frustration over the problems this causes, the physicians who want to re-visit the issue respond that additional information has come to light which they believe should be considered in making the decision. This can go on ad infinitum and key opportunities (or the ability to avoid key threats) can be lost.

This problem is made even tougher by the fact the physicians are typically equal owners of the practice and some feel that they have the right to have a say about every issue. While this it technically true, experience indicates that unless authority is granted to a leadership group, little can or will be done.

One way to reduce this is to fully empower the Board or Executive Committee to make all the decisions of the group for the term of their offices. The other members of the group have a chance to "vote" on the issues when they vote for the leadership.

Another way is to put obstacles to items returning to the agenda for discussion. The group could implement a policy that a 2/3 majority is required to bring an item back to the floor for discussion once a decision has been made.

A third solution is to empower the President or the Executive Committee to decide what to include and what not to include in the agenda of larger meetings.

"We sometimes make decisions which require the cooperation of the physicians to implement. If all physicians are not for the decision, we often have problem with gaining cooperation for implementation. How can we improve compliance with decisions?"

In a perfect world, issues would be completely discussed, thoroughly debated, and once a decision was made, all would comply with the decision. Unfortunately, that perfect world only exists in our mind.

Therefore, many group have found that when they make decisions which require physician participation, they must also include in the decision the "carrot" or "stick" that will be used to ensure cooperation. Examples could be a financial reward for participating in a meeting, a financial penalty for not finishing charts on time, or a loss of voting rights for those who do not attend required business meetings. The point is, for these issues there are two interconnected parts of the decision -- the part related to what the group needs the physicians to do, and the part related to how to ensure cooperation.

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Exhibit 1 – Board of Directors

MEMBERSHIP:

- All full partner members
- Other physicians (nonvoting)
- Administrator (ex-officio)
- Others may attend as invited

TERM:

Members will serve as long as their contractual arrangements with the practice are in effect.

RESPONSIBILITIES:

The Board is responsible for making decisions regarding the major operations of the practice. The Board sets policy for the group, performs long-range planning, and makes certain operating decisions regarding contracts and expenditures.

The Board monitors the overall performance of the practice.

AUTHORITY:

- Approves new physician positions within the group practice.
- Approves all contracts.
- Authorizes hiring of physicians.
- Approves all expenditures over $25,000.

MEETINGS:

The Board will meet the third Thursday evening of each month.

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Exhibit 2 – Executive Committee

MEMBERSHIP:

President
Vice President
Treasurer
Administrator (ex-officio)

TERM:

One year.

RESPONSIBILITIES:

This Committee is responsible for making the day-to-day decisions for the group, and reporting to the full board.

AUTHORITY:

This Committee has the following authority:

- $25,000 approval limit on expenditures.
- Make salary/benefit recommendations to the Board.
- Approves new administrative positions.
- Approves modifications to personnel policies.

The Committee may not enter into contracts on behalf of the group, but must present them to the Board for approval.

MEETINGS:

The Executive Committee will meet each Tuesday morning at 7:00 AM.

Exhibit 3 - President

ELECTION:

The President is elected in December of each year by a majority of the voting Board members.

TERM:

One year.

RESPONSIBILITIES:

- Handle the ceremonial role for the group with external parties.
- Direct the Board in policy formation.
- Lead the physician recruitment effort.
- Set agenda and run meetings of Executive Committee and Board.
- Monitor performance of Administrative function.
- Conducts performance review of Administrator.
- Create committees and appoint Chairpersons.
- Make day-to-day decisions within limits of authority.

AUTHORITY:

$5,000 approval limit on expenditures.

Exhibit 4 – Administrator Job Description

JOB TITLE: Administrator

PRIMARY FUNCTION:

The primary function of the Administrator is to plan, direct, coordinate, control, monitor and evaluate the operation and activities of the group practice, except those directly involving professional medical judgement.

REPORTING RELATIONSHIP:

The Administrator derives authority from, and is directly responsible to, the Board of Directors. The Administrator will work with the President to handle the day-to-day business affairs of the practice. The Administrator acts as an ex-officio member of the Board and Executive Committee.

REQUIREMENTS:

- Degree in Business Administration or equivalent business experience. Advanced degree (Masters in Health Administration or MBA) desirable.
- Five years administrative and managerial experience with a medical group.
- Maturity and intelligence to work with and through people.
- Ability to express himself/herself well in speaking and writing.

MAJOR RESPONSIBILITIES:

PLANNING

1. Works with physicians to develop and modify, as required, the long range plans for the practice including, but not limited to, personnel, both M.D. and non-M.D., facilities, services, areas of service, and relationships within the industry.

2. Keeps up to date on trends in medical group management by active participation in industry associations and relationships with industry peers.

BOARD INVOLVEMENT

1. Responsible for carrying out the plans and policies of the Board of Directors.
2. Attends all Board and Executive Committee meetings. Prepares and distributes minutes of such meetings.
3. Prepares Executive Committee agenda.
4. Provides feedback to the President of the Board on significant problems facing the group, including medical and non-medical.
5. Provides feedback to the President and Board on trends in the medical industry, develops and recommends ideas to enhance the long range prospects of the practice.
6. Facilitates and brings expertise to committees created by the President and Board.
7. Meets individually with each member of the Board to discuss practice needs and issues.
8. Assists Board in physician recruitment, as necessary.
9. Assures compliance with all physician agreements and contracts. Reviews and updates physician contracts annually.

PERSONNEL MANAGEMENT

1. Manages overall clinic staff organization, assignment and determines lines of organization.
2. Acts as liaison between physicians and support staff.
3. Maintains appropriate supervisory system.
4. Develops and keeps up to date policy and procedures manual, and personnel handbooks.

5. Develops and keeps up to date job descriptions and performance standards for each position.
6. Set policies and oversees supervision of business office, medical buildings and secretaries.
7. Organize and conduct regular non-physician staff meetings.
8. Recommends new staff positions with job descriptions, financial package, and impact statement to the Board through the Executive Committee.
9. Recruits and selects new personnel as well as determines suitability of retention of non-M.D. personnel through timely review of performance appraisals. Performance appraisals for secretaries are done in conjunction with the physicians.
10. Reviews salaries on a periodic basis and makes recommendations to the Board.
11. Reviews employee benefits and makes recommendations or informs board as appropriate.

FINANCIAL MANAGEMENT

1. Prepares and presents annual budget to Board of Directors for approval.
2. Informs Board through monthly reports actual performance vs. budgeted plans, and reports on appropriate productivity needs.
3. Establishes policy for accounts payable and accounts receivable and monitors activity as required.
4. Directs the day-to-day financial management of the group, including payment of bills in a manner to assure offered discounts are taken, good credit is established, and payrolls are met.
5. Establishes and supervises an adequate, cost-effective system of internal controls.
6. Monitors patient reimbursement patterns.
7. Provides direction for money management.

8. Monitors adequacy of all business insurance (including professional liability, property, etc.) and makes recommendations or informs board as appropriate.
9. Recommends, maintains and regularly reports on banking, accountant, and other financial relationships.

EXTERNAL RELATIONSHIPS

1. Investigates, analyzes, proposes and negotiates relationships with hospitals, prepaid healthcare companies, and others.
2. Approves all vendor selection and participates in selection process as required.
3. Selects/recommends/maintains banking and other financial business relationships.
4. Maintains necessary liaison with legal counsel, accountants, and consultants on matters affecting the management of the groups affairs.

MARKETING

1. Monitors overall clinic image and reports to Executive Committee areas to be addressed and assists in resolution.
2. Evaluates referral patterns and report to the Board.
3. Develops and monitors marketing plan for practice.

INVESTMENTS

1. Assures proper maintenance of building and grounds at all facilities.
2. Plans, proposes, and supervises construction of needed facilities, as required.
3. Investigates and secures professional investments, expansion, new medical equipment, etc.

4. Reports on status of investment planning for pension and profit-sharing program.

PROJECTS

1. Performs special projects as assigned by the board. For major projects, prepares formal plans and provides status reporting to the board.

AUTHORITY:

1. Hire and fire all non-provider personnel. Provides input to physicians on hiring and firing providers.
2. Approve recurrent expenditures below $_____.
3. Approve payroll expenditures.

As you might expect, our knowledge in this area is based on the fact that Latham Consulting Group has substantial experience in assisting medical groups with improving their governance through our **Governance Services**.

If we can provide assistance or answer any questions you might have, please contact us at 704/365-8889 or e-mail us at wlatham@lathamconsulting.com.