Facilitating Change in Medical Group Practices

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There is no more delicate matter to take in hand, nor more dangerous to conduct, nor more doubtful of success than to step up as a leader in the introduction of changes. For he who innovates will have for his enemies all those who are well off under the existing order of things and only lukewarm supporters in those who might be better off under the new.

— Niccolo Machiavelli

For a variety of reasons, both primary care physicians and specialists have formed increasingly larger group practices in recent years. These have taken the form of both multispecialty and single specialty groups with a combination of senior physicians and younger associates and partners. While there are marketplace rewards that may result from establishing groups of larger size, taking advantage of this potential often requires changes in governance, management structure, call schedules, compensation plans, location of practice sites, physician resource planning, and onsite medical staffing, as well as some standardization of previously independent approaches to a variety of practices. However, the ultimate success of medical group practices depends in large part on their ability to adapt to changing reimbursement methods and market factors. Theirs is an arduous task that requires an understanding of the needed changes, the obstacles to transitions, and the tactics to bring them about.

Ultimate Success of Medical Group Practices Depends in Large Part on Their Ability to Adapt to Changing Reimbursement Methods and Market Factors.

Obstacles to Change

There are multiple reasons for the reluctance of medical groups to accept more readily. Change often affects other than the core practice of medicine; it frequently involves lifestyle and financial issues. Inertia related to change in administrative or governance structures is a major obstacle. Most physician interests are directed at their day-to-day practice. The complexity of patient problems and the stress of medical decision making leave little time for thought about the other aspects of practice. So long as the organization seems to be running smoothly, there is often no incentive to consider alternatives to the present state. “If I don’t see that it’s broken, then don’t think about fixing it.”

A second obstacle to change is the physicians’ sense of independence. Due to the solitary nature of medical decision making, most physicians feel a strong sense of self-reliance. As a result, physicians are reluctant to accept the judgments and recommendations of their colleagues regarding the need for the type of changes required to improve practice performance. Even the concept that there is more to group practice than their individual contribution is alien to many physicians. A related issue is the intelligence and advanced level of education that is the hallmark of those who have achieved success in the medical profession. Most problems that require change in a group practice can be addressed by more than one solution. When individual practice members focus on their own recommendations, it becomes much more difficult to reach consensus regarding a single suggestion and the method to implement it.

Frequently, the practice governance and management structures
are inadequate to facilitate change. Lack of clearly delineated leadership roles and the tension that can occur between lay administrative leaders and the physician owners are obstacles to the successful implementation of any change process. The concept of "equal partners" in a group practice includes more than the sharing of financial benefits. Delegation of leadership responsibility, no less authority, is done reluctantly if at all by practice owners. Many groups are not organized in a way to efficiently process issues and arrive at solutions that require internal change. Paradoxically, one of the most important changes required in large groups is governance and management redesign. Any change initiative will require one or more "champions" to oversee the process and articulate the issues and suggestions. Lack of a credible champion may be the essential element leading to failure.

**Techniques to Aid in the Change Process**

A variety of tactics can be employed to overcome these barriers to the change process. These involve time, identifying appropriate individuals to aid in the process and, above all, a worthwhile concept. One or frequently more of the following methods can be employed to enable a transition effort.

For the change process to be successful, individuals must have the **insight** to see the consequences of the present state and the **imagination** to envision a better condition. These traits reside not just in the formal practice leadership. Governance and management must be willing to support constituents in evaluating and formulating insights and ideas that might at first blush appear to be self-interested efforts.

Stimulating the members of a physician practice to undertake a change process is difficult. The need for change must be presented with some **sense of urgency** as described by Kotter. The case must be made that without imminent transition, significant consequences might occur.

Physicians' ability to respond to **data and information** is a long-stated axiom. A sure way to lose credibility in any discussions with professionals is not to have the correct facts or to have bluntly incomplete information. While any change initiative should be based on internal or external findings, thorough investigation of these findings as well as of alternatives to any one identified solution is a necessity. Evaluation and presentation of the issues, especially the financial consequences of any change, is mandatory. This includes an effort to assure that the problem identified is truly a problem; e.g., if a contractual relationship is in question, has the contract been accurately interpreted or is the perceived problem non-existent?

Most situations requiring a change strategy are not entirely unique. In formulating possible changes and the associated implementation steps, it is often helpful to obtain examples of actions by similar groups as well as the outcomes of those actions. A **survey** of other groups in the area or in the same specialty can be helpful. Practice members often have contacts in other similar specialties and on their own will discuss change efforts with them. Making formal inquiries through medical group associations as well as organizing the results of informal discussions regarding the topic are frequently helpful in formulating proposals and in reassuring group members regarding the validity of the process.

A knowledgeable and credible
advocate or champion for the proposal is ideally an individual who has little to gain personally from any change in a compensation plan, schedule change, or governance restructuring. The advocate should have as his/her interest the good of the group and should maintain a strong focus on the desired outcome. Such an advocate should be able to support the rationale for the proposal as well as be able to fully and clearly explain it. He or she should be open minded and willing to consider suggestions regarding changes in the proposal. In addition, the advocate should value the concept over the specifics. Too much ownership of the details of a proposal could prevent reasonable changes from being made that might make the effort successful.

Any initial proposal will require vetting by the group. Suggestions for improvement of the proposal should be seriously considered by those advocating the change. The initial proposal should be seen as a "strawman" that can be used not only to test the group's willingness to consider a significant alteration in the conduct of its business but also as a target for improvement. It may be helpful to break down the proposal into key elements so that suggestions and criticism can be directed at specific components. This will help to prevent the overall concept from being debunked because of objections to a portion of it.

Thoroughly educating all of the members of a medical group regarding organizational, practice, or location changes is a critical but arduous task. Physicians focus primarily on the daily practice of medicine with its attendant patient relationship, medical knowledge, and risk issues. Focusing on "administrative" matters—even though they are intrinsic to the business of the medical group—is not a high priority for most practicing physicians. Garnering their time and attention, even for short periods, is not easy. A major effort must be made to engage the group members in an active discussion of the underlying issues to be confronted and of the proposal being put forward. General group meetings can be used to introduce the reasons behind the initiative and the broad concepts of a proposal. Meetings between a supporter of the change initiative and small groups of practice members can be effective in going into further detail. A major benefit of such meetings is that they serve as a forum for interaction among physician leaders/administrators and group members. Suggestions regarding the proposal that are eventually included in the final solution may be made during these meetings. Support engendered through participation in these interactive sessions is vital to arriving at a final resolution. Alternatively, those who are champions of the change process can derive important information and understanding, which might affect the ultimate outcome.

**KNOWLEDGE OF THE LEADERSHIP CULTURE OF THE GROUP IS VITALLY IMPORTANT.**

Whether in group meetings or individual physician encounters, knowledge of the leadership culture of the group is vitally important. Formal and informal leaders exist in all organizations. Particular attention should be paid to informal leadership. "Informal" physician leaders may be difficult to identify, even by other group members, and may vary depending on the subject at hand. Their influence on other physicians regarding group actions can be significant. Seeking advice and support from informal leaders can be a key factor in formulating and presenting a successful proposal. Physicians willingly consult colleagues for their ideas regarding the care of patients. However, for advice and recommendations regarding the business and organizational aspects of group practice, they are less likely to trust the opinion of their partners. Obtaining "outside" help from a consultant may facilitate a change process that has run into some difficulty. The "prophet from another land" may lend credibility both to the rationale for the change as well as to the proposal. Consultants can bring experience from other groups that might have gone through a similar process and can advise the organization regarding pitfalls and alternatives related to the proposal under consideration. They approach the situation from a neutral position without the self-interest that group members may have. As a result, their advice is given greater standing than that of group leadership.

When proposing significant alterations to practice governance, the group compensation plan, or other major organizational aspects, it may be necessary to include a "sunset provision." Such a provision may enable those who favor the plan but are concerned about possible unintended consequences of the change to support the proposal. The provision may require a review by the group with the guarantee of a vote at a specified future time or may automatically terminate the change unless a majority supports continuation. Six-month limits might be appropriate for compensation plan alterations, but governance changes should be given at least two years to demonstrate success. Those who champion the proposal should be reassured that any worthwhile transformation will stand the test of time.

It is not always possible to be assured of complete consensus regarding a change initiative. During the period of education and discussion, a small minority of members
may express strong objection to a proposal which appears to be otherwise generally accepted by the group. These members may have rational objections or even reasonable suggestions that should be considered in finalizing the proposal. Sometimes their stance is less thoughtful. It is not uncommon for the “devil’s advocates” to take a strong stand during the discussions, but actually support the proposal when they learn that the vast majority of the group favors it. These individuals deserve their time at the podium but should not deter the leadership from bringing the issue to a vote.

**MAJOR ALTERATIONS IN GROUP GOVERNANCE, ORGANIZATION, AND PRACTICE LOCATIONS, AND OTHER SUBSTANTIAL CHANGES REQUIRE BUY-IN FROM A LARGE MAJORITY OF THE PRACTICE TO BE SUCCESSFUL.**

Major alterations in group governance, organization, and practice locations, and other substantial changes require buy-in from a large majority of the practice to be successful. It may be necessary to therefore require super majority voting on such proposals. This may require a temporary alteration in the standard voting rules of the group. Such an alteration can be included in the proposal itself. In addition to assuring that the change has widespread support, the requirement for a disproportionate majority vote can be reassuring (as with the sunset provision) to the supporters who continue to have some concerns. Two-third or three-quarter majorities may be appropriate for such major changes.

**Summary**

As medical group practices have grown in size and complexity, the need for significant changes in various organizational aspects—including structure, governance, work and call reduction, and compensation plans—is often necessary. The independent nature of physicians as well as their individuality can inhibit the ability of practice leadership to promote necessary changes. Inertia and the physicians’ desire to focus on medical practice rather than the business of medicine also impede the change process. Several tactics are available to help facilitate the change process. These include techniques to enhance the development of a proposal as well as to educate the group regarding both the rationale for change and the credibility of the recommended direction.

**References**


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