MANAGING YOUR NEPHROLOGY PRACTICE: Keys to Success in an Ever-Changing Environment
DaVita® thanks the physicians involved with this project for volunteering both their time and knowledge to create this Nephrology Practice Governance and Management tool

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Produced by Nephrology Practice Solutions
Introduction to Governance and Management

Welcome to Managing Your Nephrology Practice: Keys to Success in an Ever-Changing Environment. This toolkit discusses principles and provides guidelines to the governance and management of nephrology practices. If you are reading this, it is because you are sensitive to our rapidly changing times and are seeking ways to improve your practice operations—and maybe your lifestyle, too! We are writing this after conversations with many of you who are practicing nephrologists, observing your environment and asking questions that probe the nature of running your practice as an effective, efficient business. The sections included in this toolkit were selected from hours of communications, presentations and strategy sessions with nephrologists and practice managers, and then organized by physician experts who have experience and proven track records in these areas.

We think we can all agree that the commonly mentioned phrase, “the practice of nephrology is challenging,” is an understatement of our current reality! Over the past several years, we have seen increased scrutiny of the clinical practice of nephrology, including utilization of ESAs, changing focus to CKD patients and their management, vascular access management, and tightened oversight of dialysis, including medical directorships. These represent some of the key “moving parts” of the business of nephrology.

The recent downturn of the economy and political interest in a single-payer system has magnified the stress on our businesses. Faced with increased costs (overhead), increased government regulations and decreased reimbursement, we are, more or less, in a perfect storm.

In our capacities as DaVita® Vice President, Medical Affairs and Vice President of the Nephrology Practice Solutions, we have had the rewarding experience of meeting with representatives of more than 200 practices. Common problems have been shared with us. The questions that continually come up include:

• How can I sustain my practice?
• Should we add another nephrologist?
• Should we add a midlevel provider (nurse practitioner or physician assistant)?
• How do we let senior partners reduce their call coverage?
• How do we gain market share?
• How do we get all of our nephrologists on the same page for call coverage, compensation and life balance?
• How do we best manage this business?
• What skills do I need to address each of these moving parts?
• What is the best method of governance for us?
• How do we measure productivity?

These are all excellent questions. Generally, nephrologists’ concerns fall into two major categories: practice governance and practice management. Common concerns include methods to improve practice fundamentals; practice strategies; efficient decision-making; how to recognize when change is needed, and how to reduce the barriers to such change; reducing practice discord, and developing efficient and effective utilization of diminishing resources.

Each of these issues is discussed in this toolkit and will pertain to your practice to different degrees. The guidelines to address these issues are written and edited by nephrologists who are recognized for their accomplishments in these areas. This toolkit is, therefore, a compendium of approaches to common governance and management issues. Each author and editor has a different writing style and approach. There is some
crossover and duplication of issues, but this underscores the importance of these issues to the nephrology practice. Authors and editors are in practices having as few as three nephrologists and as many as 30. They represent practices started three years ago and practices started 40 years ago!

Practices vary widely in their size, management expertise and scope of services. It behooves each of us to study, reflect and apply those principles that specifically apply to us the most. We are sure once you have done so, you will be re-energized to develop those strategies, operations and structures to improve not only the management but the governance of your practice. We hope that then, you will be able to look back and say, “Yes, I have seen improvement in my lifestyle, time management, bottom line, my relationships with colleagues and more!”

We are starting this toolkit with a Case Study, as many of the mistakes we see in practices are represented in the Case Study, with the same poor outcomes. Perhaps you will see your own practice represented. If not, certainly some of the characteristics of one of the two competing practices will be evident in your practice. Which one looks more like yours? What mistakes have the practices made?

It has been our great pleasure to work with the authors and editors in the following sections. We all agreed that a practical “how-to” approach to these issues was long overdue. We hope you enjoy reading these sections as much as we have enjoyed reviewing and editing them for you.

Sincerely,

Robert Provenzano, MD, FACP, FASN
Peter C. Donald, Vice President, Nephrology Practice Solutions
# Table of Contents

## Governance & Management of Nephrology Practices

### Case Study  Governance & Management Team
- Part I  
- Part II  
- Part III  

### Module 1: Practice Fundamentals:  
*Mission, Vision, Values and Capacity*  
*William Cleveland, MD*  
*with edits by Michael Shapiro, MD*

- Questions  
- Defining your culture through core values  
- Developing the mission and vision statements for your practice  
- Forming practice strategy and developing practice goals  
- Providing adequate resources  
- Providing enough manpower to create capacity and sustainability  

### Module 2: Narrowing Vision Without Losing Sight–Developing a  
*Practice Strategy*  
*Adam Weinstein, MD*  
*with edits by Michael Shapiro, MD*

- Questions  
- The constraints of vision: market and practice resources  
- Differentiating your practice from competitors  
- Using workflows to achieve goals  
- An active mind is prepared for change  

### Module 3: Spend Time For Effective Decision Making  
*Tim Hines, MD*  
*with edits by Paul Turer, MD*

- Questions  
- Practice structure and its influence on decision making  
- Management committees  
- Management compensation for decision making  
- Agreeing upon a mission statement, vision, strategy and goals  
- Meeting often enough to develop group cohesion  
- Founder’s rights
## TABLE OF CONTENTS continued

**Module 4: How To Produce Change**  
Chris Hebert, MD  
with edits by John Robertson, MD

- Questions ................................................................. 37
- Sponsoring change ..................................................... 37
- The need for change agents .......................................... 38
- Different roles in the change process ............................... 39
- Overcoming barriers to change ...................................... 40
- Creating a culture for change ......................................... 40
- Creating a change plan .................................................. 40
- Vignette for the change module .................................... 42

**Module 5: Reducing Practice Discord**  
John Maynard, MD  
with edits by Paul Turer, MD

- Questions ................................................................. 46
- Hire the right doctors, then monitor for progress ................. 46
- Practice nephrology as a group ...................................... 47
- Everyone’s schedule and compensation must be fair ............ 47
- Communicate in an effective manner .............................. 47

**Module 6: How To Efficiently and Effectively Utilize Your Resources**  
Stuart Senkfor, MD  
with edits by Michael Shapiro, MD

- Questions ................................................................. 50
- Utilizing resources ....................................................... 50
- Orientation ...................................................................... 50
- Compensation .............................................................. 51
- Part-time status ............................................................ 52

- Comments from the Authors and Editors on the Case Study .... 56

- Appendix ................................................................. 58

- Glossary of Terms ..................................................... 62

- Additional Resources ................................................. 64
### Table of Contents continued

**About the Authors and Editors**

William Cleveland, MD ......................................................... 66
Chris Hebert, MD ................................................................. 66
Tim Hines, MD ................................................................. 66
John Maynard, MD ............................................................. 67
Robert Provenzano, MD ....................................................... 67
John Robertson, MD ............................................................ 68
Stuart Senkfor, MD ............................................................... 68
Michael Shapiro, MD .......................................................... 69
Paul Turer, MD ................................................................. 69
Adam Weinstein, MD .......................................................... 69

**Additional Contributors**

Peter Donald ................................................................. 70
Anders Christofferson ....................................................... 70
CASE STUDIES
GOVERNANCE & MANAGEMENT TEAM
**Nephrology Care Associates P.C. (NCA) — Part I**

**Practice demographics:**
- Three nephrologists, Dr. Jones, Dr. Strathmore and Dr. Edmonds. Dr. Jones and Dr. Strathmore started the practice eight years ago; Dr. Edmonds joined the practice two years ago. They are the only nephrologists serving the community.
- For call coverage, the doctors cover two hospitals; the combined average daily renal patient census is 25. The doctors each take call coverage, one week on, two weeks off.
- They are Medical Directors for two dialysis centers.
- They have 250 ESRD patients.
- The doctors started compensation on productivity, but went to equal share this year. All three have a strong work ethic and trust each other.
- The doctors promoted their lead billing person to practice manager last year.

**Abstract:**
The three doctors are quite pleased with their service to the community. They feel the referring physicians are very happy with their service and clinical capabilities.

The practice manager has struggled in her new position. The rest of the personnel do not especially like her. Dr. Jones, who assumed leadership of the group (he is the most senior physician) periodically has to work through personnel issues with the rest of the office employees.

A fellow, Dr. Sermon, who grew up in the community, has asked to join the group. Dr. Sermon is completing his fellowship in a program that Dr. Jones and Dr. Strathmore do not believe is as strong as the one they attended. The doctors felt he was not capable of practicing nephrology at their level. In addition, the doctors did not want to see any decrease in their level of compensation. They thought they should bring on a new associate in the next three years, and wanted to bring in a fellow from the same program they attended as they felt it was one of the best in the nation.

The doctors learned another dialysis provider was planning to build a dialysis unit in the community, and was recruiting Dr. Sermon to be the Medical Director as soon as he finished his fellowship. The doctors met monthly to review business and clinical matters. They briefly discussed the fact that another dialysis provider was coming to town along with Dr. Sermon.

The doctors were not sure how the community might grow, especially in the western suburbs. They thought they could handle the ESRD population growth rate, even if they had to work a little harder.
They were sure of one thing: They were not too concerned as they felt Dr. Sermon, if he came into the community, would not be embraced by their referring physicians.

In order to respond to this potential threat, the doctors considered the following alternatives for action:

(Decision Making)

1. Go to the hospital credentialing committees and warn the committee chairmen about Dr. Sermon, whom they feel is not capable of practicing medicine at their level of quality. (Practice Strategy)
2. Go to the hospital VP of Medical Affairs and tell him/her about the potential problems of having a doctor who was trained in what they felt was an inferior fellowship program. (Practice Strategy)
3. Go to their dialysis provider to see if they would build another dialysis unit to compete with the new provider coming to town. (Practice Strategy)
4. Monitor the situation in their two-hour monthly meeting by adding this situation as a recurring agenda item. (How to Produce Change)
5. Regarding personnel issues, Dr. Strathmore suggested he become the mentor of the practice manager. (Practice Fundamentals, Resource Deployment, Practice Discord)
6. Physicians are reconsidering the timing of adding a fourth doctor. (Practice Strategy, Decision Making, Practice Fundamentals, Resource Deployment, How to Produce Change)

Are these sound choices? Are there other things the group should consider?
Nephrology Care Associates P.C. (NCA) — Part II

Several years later (since Part I of the Case Study) NCA has grown, but they have lost market share to Dr. Sermon, who did indeed open a practice in town.

The following represents an updated profile of NCA:

**Practice demographics:**
- Five nephrologists
  - Two who have been with the practice for 15 years, Dr. Jones and Dr. Strathmore
  - Dr. Edmonds, who has been with the practice nine years
  - One relatively new partner who has been with the practice for four years, Dr. Cantor
  - One new associate, Dr. Abrams, who joined last July
- One nurse practitioner
- Call coverage
  - Five hospitals
    - Drs. Jones and Strathmore wish to cut back on weeknight and weekend hospital call. Drs. Edmonds and Cantor do not mind doing hospital call. However, there is no precedent in the practice structure to decrease hospital call responsibilities
    - Two hospitals are very busy
    - The combined average daily census for all the hospitals is 35
    - Physicians are on a rotation model. When a physician is on vacation, one physician covering all hospitals can occur
  - Seven dialysis centers
- Patient volume
  - 440 ESRD patients
  - 24 PD patients (included in the 440)
- Compensation plan
  - Equal share among partners of dialysis and hospital revenues; the office revenues are paid on productivity
  - The new associate is on a fixed salary

**Abstract:**
Dr. Edmonds and Dr. Cantor are not happy with their compensation plan having equal share of hospital revenues. Dr. Abrams feels like he is bearing a bigger share of the load than the older partners, Drs. Jones and Strathmore, and is starting to resent his situation. Dr. Abrams did not expect to work this hard in private practice. His family and personal interests (biking and rock climbing) came first in his quest for life balance. In addition, he has not been included in the decision making of the practice, nor has he been asked to take on any administrative activities. Drs. Jones and Strathmore feel that this new associate does not yet have the capacity to add value to the management of the practice and that, as a new associate, it is none of his business.

Dr. Jones, the most senior physician, is the group leader. He does not receive any compensation for this position and feels like he should not have to cover an equal share of hospital call because of his managerial duties.
Others in the practice do not believe he spends much time on the management of the practice, and see it as his way to “cop out of call.” In addition, they put a higher value on call than they do administration. They feel he should take a reduction in pay if he opts out of call. The others feel more should be done by the practice manager. She is relatively sharp on billing, but does not have the capacity or respect of the practice personnel or partners to do more.

At a recent strategic planning meeting with a consultant, the doctors were surprised to find out they were losing market share in their catchment area. A competing group of six nephrologists, Westside Kidney Associates (WKA), was growing at 7% per year, and Nephrology Care Associates was growing at only 3% annually. Two years ago, their competition was only three doctors. WKA now had almost as many ESRD patients as NCA, and had established very good relationships with referral sources. Dr. Jones and Dr. Strathmore were surprised with the loss of market share, as they felt the two leaders of the other group, one being Dr. Sermon, practiced substandard medicine. Two more nephrologists just started another nephrology practice in the community. The addition of these two doctors could further erode their market share.

The following RPA benchmarks were noted:

<table>
<thead>
<tr>
<th>Category</th>
<th>NCA total</th>
<th>RPA per FTE nephrologist¹</th>
<th>NCA per FTE nephrologist</th>
</tr>
</thead>
<tbody>
<tr>
<td># ESRD pts</td>
<td>440</td>
<td>82.0</td>
<td>88.0</td>
</tr>
<tr>
<td>NP/PA</td>
<td>1</td>
<td>.38</td>
<td>.2</td>
</tr>
<tr>
<td>Admin managerial staff</td>
<td>1</td>
<td>.43</td>
<td>.2</td>
</tr>
<tr>
<td>Offices</td>
<td>1</td>
<td>.65</td>
<td>.2</td>
</tr>
<tr>
<td>Hospitals served</td>
<td>5</td>
<td>1.17</td>
<td>1.0</td>
</tr>
<tr>
<td>Dialysis centers served</td>
<td>7</td>
<td>1.77</td>
<td>1.4</td>
</tr>
</tbody>
</table>


At the strategic planning meeting, several issues were identified:

1. Not every doctor in the practice responds quickly to hospital consult requests. (*Practice Strategy*)
2. Some doctors in the practice have a two-month wait period to see office patients. They are not willing to give up any patients to others who are not as busy in the practice, as they are on productivity for office revenues. (*Practice Discord*)
3. The youngest partner, Dr. Abrams, does not want to add any more physicians to the practice as he feels the existing doctors’ income level would go down, and he still has a lot of debt (student loans) to cover. (*Practice Fundamentals, Mission, Core Values*)
4. Dr. Cantor is not happy about the drive time for covering one specific dialysis center. He complained that he never had any time for his family. (*Practice Fundamentals, Resource Deployment*)
5. One doctor complained that he didn’t see that the practice had made any decisions in the last few monthly meetings, as they could never seem to agree on anything. (*Decision Making*)
6. They feel they are losing some referrals (that they used to get) in the hospitals. *(Practice Strategy)*

7. They are losing more market share on the west side of the town, where they have no office, than on the east side. *(Practice Strategy)*

8. They are not sure what percentage of dialysis center patients are seen four times monthly. The N.P. is supposed to make sure this gets done. *(Resource Deployment)*

9. The doctors could not decide how to change their economic model to redistribute income in order to facilitate change. They could not agree on the value of various activities. *(Practice Fundamentals, Decision Making, Resource Deployment, Practice Discord)*

The doctors decided to take immediate action. *(Decision Making, How Do They produce Change?)*
Nephrology Care Associates, P.C. (NCA) – Part III

Abstract:
Two months after the strategic planning meeting with NCA, a major development took place. The provider that NCA was affiliated with bought the small dialysis provider that served the community. The doctors in NCA were wondering if they should merge with Westside Kidney Associates (WKA). Dr. Jones and Dr. Strathmore decided to meet with Dr. Sermon and Dr. Beeman, the leaders of WKA. They determined the following in their meeting:

<table>
<thead>
<tr>
<th>Item</th>
<th>NCA</th>
<th>WKA</th>
<th>Potential advantages/disadvantages of merging</th>
</tr>
</thead>
<tbody>
<tr>
<td>ESRD patients</td>
<td>442</td>
<td>428</td>
<td>With 870 total patients, the practices could have a vascular access center</td>
</tr>
<tr>
<td>Doctors</td>
<td>5</td>
<td>6</td>
<td>The combined group of nephrologists would be the largest nephrology practice in the market</td>
</tr>
<tr>
<td>ESRD patient growth rate</td>
<td>3%</td>
<td>7%</td>
<td>Average of 5% annually</td>
</tr>
<tr>
<td>NP/PA</td>
<td>1</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Administrative staff</td>
<td>1</td>
<td>1</td>
<td>Neither one strong enough to lead combined practice. The NCA practice manager, upon hearing from Dr. Jones that he was meeting with Dr. Sermon, indicated that she would not accept working for the WKA practice manager</td>
</tr>
<tr>
<td>Offices</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Hospitals</td>
<td>5</td>
<td>5</td>
<td>Eliminate duplicative weekday coverage*</td>
</tr>
<tr>
<td>Call coverage weeknights and weekends</td>
<td>2 of every 5 weeks (1 on east side and 1 on west side)</td>
<td>1 in 3 (1 on east side and 1 on west side)</td>
<td>Could possibly go to 1 in 5* with combined group of 11 nephrologists</td>
</tr>
<tr>
<td>Dialysis centers served</td>
<td>7</td>
<td>5</td>
<td>Eliminate duplicative center visits and geographic coverage easier for practitioners should groups combine</td>
</tr>
<tr>
<td>Item</td>
<td>NCA</td>
<td>WKA</td>
<td>Potential advantages/disadvantages of merging</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>------------------------------</td>
<td>------------------------------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>Compensation</td>
<td>Equal share plus one on salary</td>
<td>Equal share but two new docs on salary</td>
<td>More revenues can be realized by combined group</td>
</tr>
<tr>
<td>Lead physician</td>
<td>Jones</td>
<td>Sermon</td>
<td>Difficult decision here</td>
</tr>
<tr>
<td>Mission, core values, life balance</td>
<td>Strong work ethic in practice, no stated vision, mission, or values</td>
<td>Belief in work/life balance and creating capacity for growth, no stated mission or core values, but vision is to be the best nephrology practice in the community</td>
<td>Groups will need to meet at length to determine work/life balance, what a combined practice would stand for, and what a potentially revised vision and strategy would be</td>
</tr>
<tr>
<td>Compact (see Glossary of Terms)</td>
<td>None written</td>
<td>Practice has a written document that each new practitioner has to sign. It states the expectations of the practice for the new practitioner and what the practice is to give in return</td>
<td>Will expectations for practitioners in each group be the same once combined?</td>
</tr>
<tr>
<td>Decision making</td>
<td>No decision is made if there is a dissenting voice</td>
<td>Executive committee of Dr. Sermon and Dr. Beeman make most operational and strategic decisions. Entire practice is brought in on major issues</td>
<td>Practices will need to determine how to manage larger group</td>
</tr>
<tr>
<td>Strategic planning</td>
<td>Planning done for short-term issues, decided in the monthly practice meeting</td>
<td>All plans oriented to picking up market share. Practice meets weekly to discuss patients, business items and practice strategy</td>
<td>Practices will have to develop a more formally agreed upon strategy and planning process</td>
</tr>
<tr>
<td>Item</td>
<td>NCA</td>
<td>WKA</td>
<td>Potential advantages/disadvantages of merging</td>
</tr>
<tr>
<td>-----------------------</td>
<td>------------------------------------------</td>
<td>------------------------------------------</td>
<td>----------------------------------------------</td>
</tr>
<tr>
<td>Producing change</td>
<td>Doctors not interested in a lot of change</td>
<td>Growth of practice has produced constant change. Doctors desire to achieve life balance; as a result there is little resistance to bringing on more doctors</td>
<td>Will NCA be able to change this much?</td>
</tr>
<tr>
<td>Reducing practice discord</td>
<td>Discord in practice due to call coverage, lack of agreement on value of administrative activities, lack of trust in each other’s work habits</td>
<td>Lack of agreement in regard to pay for Drs. Sermon and Beeman for administrative duties</td>
<td>Practice discord increase?</td>
</tr>
<tr>
<td>Resource deployment</td>
<td>Drs. Jones and Strathmore not happy with call coverage</td>
<td>Doctors okay with call coverage</td>
<td>Drs. Jones and Strathmore see a merger as a way to cut back on week night and weekend calls</td>
</tr>
<tr>
<td>EMR</td>
<td>None</td>
<td>EMR installed in practice</td>
<td>Dr. Jones is not in favor of getting an EMR</td>
</tr>
</tbody>
</table>
Following the meeting, Drs. Jones and Strathmore saw the advantages of a potential merger as:

- Reduced call coverage. If the two groups of doctors would go for 1-in-4 coverage for weeknights and days, they could possibly opt out of call coverage. As an offset, they would take over management of the larger group.
- More dollars for the practice if they could start an access center.
- Their purchasing/negotiating power would be enhanced through their market leverage.
- Given the changing reimbursement climate, having the larger group would help sustain the practice.
- Ability to afford better management.

Drs. Jones and Strathmore saw the following disadvantages of the merger:

- Loss of autonomy. They felt comfortable influencing their group of five doctors. They were unclear how leading a group of 11 doctors would work.
- They were not sold on combining the billing operations; WKA processed their billing with their EMR.
- They did not see the practices as equal in stature. They had more assets and were wondering if they should require WKA to buy into their practice. There is no formula in place to assess the practice values.
- They were not sure Drs. Sermon and Beeman would like their practice manager, and they were afraid of losing her if she was not named practice administrator over the combined group.
- They saw the process of merging as a long, expensive and difficult road to take.
- They were fearful of reduced compensation.

Following the meeting, Drs. Sermon and Beeman met as well. They saw the advantages of the merger as:

- A competitive plus as the combined group would be the largest in the market.
- An opportunity for an access center, which would provide the physicians with more money and perhaps better patient care.
- Some enhanced call coverage; they did not want to be “hammered” when they were on call.
- The possibility of establishing a robust CKD program.
- An opportunity to bring on better practice management.

Drs. Sermon and Beeman were worried about the following:

- Who would lead the practice post-merger?
- What would the practitioners believe in for life balance, culture, core values?
  - Less income and better life balance?
  - Less income and more excess capacity, thus making practicing easier?
  - More income with less time off?
  - More income and fewer practitioners, resulting in leaner capacity?
  - Teamwork or everyone for themselves?
  - Will work hours and work patterns mesh?
- Is the personal chemistry between the physicians in the group OK?
- They felt Dr. Jones, being the senior doctor, would expect to lead the combined group. They were not in favor of this.
- How would the rest of WKA feel if not all doctors adopt their EMR?
- How should new doctors participate in ownership of the vascular access center and other real estate ventures?
Dr. Sermon and Dr. Beeman thought of some alternatives:
1. Collaborate on a vascular access center (VAC); add two interventional nephrologists who could help with call coverage. Share weekend coverage with NCA.
2. Delay a merger with NCA until Drs. Jones and Strathmore retire.
3. Merge now, but don’t include doctors who can’t share the new vision of the larger group.
4. Instead of merging with NCA, approach the new practice of two nephrologists and see if they would consider joining WKA.

Should NCA and WKA proceed to merge?

What major obstacles will the practices have to overcome to take advantage of the VAC revenues and the potential of reduced call coverage if they merge? What barriers are there?

Are there any deal-killers for either practice?

What problems do the practices face by having different cultures?

Do you expect the NCA doctors, without a compact (See Glossary of Terms) to think the way the WKA doctors, with a compact, do in regard to change and their allegiance to their respective practices?

Should they obtain independent valuation? If so, how?

It appears WKA may be the more flexible practice with regard to change. Is NCA poised to change? If not, why?

Could there be any antitrust issues (there is a third nephrology practice in town now)?

Should they merge, what governance structures would you see as being advantageous?

If issues in the three parts of this Case Study sound familiar, perhaps you will find answers to these problems and others in this Governance and Management Program.
MODULE 1

PRACTICE FUNDAMENTALS:
MISSION, VISION, VALUES AND CAPACITY

William Cleveland, MD
with edits by Michael Shapiro, MD
Can you answer these questions in regard to your practice?
Mission, vision, core values, life balance

- Can you describe the difference between a mission and vision statement?
- What is the physician’s role in realizing the mission of the practice? How do you “spread the word” in your practice?
- How do you develop a “group culture?”
- What are the goals of the group? How do you balance the differing needs of a heterogeneous group?
- Are there goals that are not being met? Why is this? Do you have a plan?
- What defines the market for a nephrology practice? List the elements in the context of your own practice

Defining your culture through core values
A practice’s core values are the broad principles that reflect the organization’s philosophy and guide the way it operates. These principles provide the foundation upon which the organization navigates through its mission. These core values, in turn, help to define our organizational culture.

In our training as physicians and nephrologists, as well as in our growth as human beings, we have acquired individual core values. Our sense of right and wrong, and how we aim to treat ourselves and others, provide common ground and a foundation upon which organizations (including medical practices) define what they want to be, what they want to accomplish, and how they would like to be perceived in the community.

A glance at a variety of corporate websites reveals a typical listing of key value words or phrases that are chosen so as to readily identify--to both the firm’s employees and the outside world--what the organization sees as its behavioral principles. Many organizations list several core values. Listed below are examples of those frequently found in healthcare organizations.

- **Quality**
  Quality recognizes excellence as a universally-desired goal in healthcare organizations as it applies to clinical service, as well as administrative and managerial services.

- **Team concept**
  This core value recognizes that a successful nephrology practice requires the services of multiple people with different skills working together effectively.

- **Knowledge**
  As a core value, knowledge recognizes our continuous pursuit of clinical, scientific and business information and understanding as it advances our mission and vision.

- **Integrity**
  Integrity recognizes the importance of honesty and accountability to our organization, without which no organization is sustainable.

- **Patient centered**
  A patient-centered core value recognizes that patient service is the reason we exist, and that we should be judged by how well we provide patient service.
Developing the mission and vision statements for your practice

Mission and vision are related but separate organizational concepts.

**Mission** refers to the fundamental purpose the practice seeks to fulfill in the community.² It remains a fixed concept over time. The needs of the community, and the organization’s commitment to meeting those needs, dictate the longevity of the mission. Strategies and tactics may change over time as the environment changes, but the mission generally remains constant. The mission statement can be thought of as a response to the question, “Why does our company exist?”

A mission statement expresses this purpose, and typically includes—in a broad sense—the services the organization seeks to provide. A mission statement will provide direction for what types of professionals, and how many, will be needed to achieve the firm’s purpose.

**Vision** illustrates the mission, describing the organization’s goal of how it will look in the future.

The vision statement sets the tone and strategic course for the practice, taking into consideration the practice’s mission, core values, strategy and market. Thus, a well-defined vision can serve not only to articulate goals, but to distinguish one practice from another. In addition, it sets new heights of excellence and appropriately aligns ambition with existing strengths and future opportunities.

A vision statement strikes the balance between inspirational and practical, comprehensive and focused, value-driven and theoretical.³ A successful vision statement can rally all members of a practice to facilitate its achievement.

Developing a mission and vision statement is vitally important for any organization. It serves as a reference and roadmap to help make decisions and manage the practice.

We and others have found that meeting to discuss and resolve the following types of questions is fundamental to developing the practice’s mission, vision and values.⁴

1. Why do we exist?
2. Why is our existence important?
3. What services will we provide?
4. What is our geographic service area?

⁴ Silversin, J and Kornacki, MJ, *Leading Physicians through Change*
By answering these questions, the practice’s physicians can craft or revise their mission and/or vision statements. More importantly, such a meeting or series of meetings affords the group an invaluable opportunity to reflect on its strategy; i.e., identifying and implementing the specifics of the path to successful differentiation from its competitors; how it will do business so that it becomes the practice of choice within its market.

As we have done in our practice, the organization’s vision statement may be developed or revised using the following steps:

1. Review the practice’s mission.
2. Organize and review data, including the practice’s performance, market conditions and forecasts.
3. Trend the data to suggest how the above data will look in the future.
4. Assess the practice’s strengths and weaknesses.
5. Assess what members of the practice and others outside the practice think regarding its strengths and weaknesses.
6. How would we like to envision the practice in the future?

Senior practice leaders might then consider the above and compose a draft document.

At this point, following completion of the original draft, all physicians should be invited to participate in the process by reviewing the draft with respect to the six statements and questions above. During this vision statement draft review, suggestions and new questions could then be entertained and discussed in an effort to have all members participate in the creation of the practice’s vision.

Below are the mission and vision statements from our practice.

**Mission**

Our mission is to provide excellence in healthcare with emphasis on hypertension and kidney diseases. **Southwest Atlanta Nephrology P.C.** prides itself on delivering personalized, educational and preventative services that provide long-term solutions not only for the patients we service, but also for the communities where we live and work.

**Vision**

Southwest Atlanta Nephrology will be Metropolitan Atlanta’s leading patient centered, community focused Nephrology practice recognized for its:
- Excellence in Nephrology patient services
- Focus on providing education for patients and family members
- Physician leadership in our community
- Contributions in nephrology research that seek to improve healthcare for all patients

**Forming practice strategy and developing practice goals**

“The best way to predict the future is to invent it.” – Immanuel Kant

“The purpose of strategy is alignment within the organization.” – Michael Porter

All organizations can benefit from a well-articulated strategy. A clear strategy enables achievement of mission and vision for competitive success. Such a strategic plan can be revised from time to time as market, regulatory, legal and financial conditions change.

As discussed in more detail in Module 2, a strategy statement is essentially a description of how the organization will outperform its competitors, what it will do that its competitors are not doing, and/or how it will do it
differently. Will our practice differentiate itself from and out-compete others based upon lower prices, higher quality or better service? Which of these, or which combination of such differentiators, is most attainable for a nephrology practice? Will we enhance our strategic position by aligning with a particular dialysis provider, insurer, hospital, etc.?

Whether the practice is large enough to have a management, executive or planning committee within its governance structure, or is small enough to simply have one or two physicians informally sit down together to make strategic decisions, the task at hand is more easily accomplished if pertinent data is available, such as:

1. Key practice performance metrics (e.g., ESRD and CKD census, lag time to see new office patients, revenue per FTE physician, overhead costs, etc.).
2. Trended productivity results with projections for the near to mid term (e.g., dialysis patients per FTE physician, 4-visit MCP capture rate, number of new patients to the practice per month/quarter/etc.).
3. Market data such as patient demographics, insurance mix, population growth in the local community, and information on competitors in the market.
4. Patient, referring physician and employee satisfaction survey results.

Thus the group’s relative position in the market—e.g., via a SWOT Analysis (Strengths, Weaknesses, Opportunities and Threats)—can be identified, resulting in a list of top priorities for immediate and long-term action. The group’s strategy then emerges as a means to identify and sustain a competitive advantage over its competitors, and instructs the company’s management team on the operational details that are required to make good on the strategy. This organization alignment is discussed in more detail in Module 2.

Providing adequate resources
(Staff time to think about implementing practice strategy and goals)

Successful creation of the operational framework, physician support systems, and appropriate attitude and behavior of the practice’s employees requires company-wide understanding of the practice’s mission, vision, values and strategy. If the purpose of strategy is alignment within the organization, then the development, implementation and maintenance of well-constructed operational processes and support systems is critical to bringing the practice’s goals to fruition. Here’s an example: The group decides that it wants to out-compete its crosstown rivals by providing faster and better customer service to the referring physicians and their patients. Once the management team knows this, they can more confidently design a system whereby incoming calls for new appointments become a priority; they can work with the practice’s physicians to maintain adequate capacity (office slots); assist with getting consult letters back to the referring physicians in a timely manner, etc. An electronic medical record-keeping system becomes more relevant in this setting. It becomes clearer to see that a successful strategy requires aligned participation by all members of the nephrology practice.

Physician leadership and senior management might thus be expected to devote larger amounts of time to these processes than other physician members of the practice. If the practice acknowledges this, the time and money required to be devoted to the successful preparation and implementation of the organizational plan (mission, vision, goals, values, strategy) might then be considered a critical and necessary investment in the practice rather than an excessive, low-priority expense. The dividend or return on this investment (ROI) can be quite meaningful and sustained. As a famous philosopher of our time, Yogi Berra, has said, “If you don’t know where you’re going, you’ll never get there.” We don’t know to whom we should attribute an equally relevant phrase, “Put your money where your mouth is!”
Providing enough manpower to create capacity and sustainability

The manpower or physician full-time equivalent (FTE) requirements for any given nephrology practice will thus vary depending on physician preferences and the conclusions reached from the exercises discussed above:

1. Practice mission, vision and strategic plan.
2. Number and geographical location of practice sites: office clinics, dialysis centers and hospitals.
4. Use of physician extenders.
5. Distribution of patient service activities among the physicians (dialysis and hospital rounds, office patients, medical director duties, teaching responsibilities, etc.).
6. Projected growth targets.

Each practice thus benefits from careful consideration of these factors when deciding how many physicians are needed for hospital, office and dialysis rounds now and in the foreseeable future, and whether or not collaboration with RNs, NPs, PAs, etc. fits with the group’s goals. A macro-level analysis of the practice’s workload by location and patient census at the various dialysis units, offices and hospitals permits a micro-level assessment of each provider’s capacity, efficiency and effectiveness in providing the required services in the manner that optimally incorporates these factors. Thus, questions such as “Are we providing the desired level of service that fits our mission, values, vision and strategy?” and “How can we accomplish this most efficiently without compromising our foundational values and goals?” can focus the practice’s physicians on the relevant issues and stimulate discussion about what’s best for the organization in its quest for success and physician work/leisure “life” balance.

Ideally, the practice’s provider deployment model should be reviewed from time to time to see if driving time can be minimized, workload is being evenly distributed, or greater efficiencies can be achieved. It may be desirable to consider the use of physician extenders to leverage physicians’ time.

After the provider deployment model has been in use and budget targets are achieved, consolidation of existing provider assignments or recruitment of new physicians or adding new practice sites can be considered to help foster practice efficiency and growth.

National or regional statistics for nephrologists that include dialysis patients per physician, physicians per office site and physicians per dialysis center can be used as a yardstick to benchmark one’s practice against national or regional averages.

While the foregoing has focused mainly on achievement of success at work, most physicians—like their non-physician friends, relatives and associates—also strive for some semblance of balance in their lives. We might generally define such balance as adequate time for family and leisure activities. Michael Shapiro postulates that the answer to “What do physicians want?” should be broadened beyond strictly financially defined “shareholder value” to include “the 3 S’s.” The “3 S’s” are job and family Security, creation of wealth (i.e., Savings) and professional Satisfaction.5

Each of these three life balance components is uniquely weighted by each physician in a group, and tends to change with time. Younger partners without a family to support are likely to have a different ordering of such priorities than their partner with young children at home, or a more senior physician who is close to retirement. Not that any of these three factors ever becomes unimportant; rather, which is most important might shift with time and circumstance. Module 6 tackles the issues surrounding such priorities, such as part-time status and the challenge of reducing on-call responsibilities.

MODULE 2

NARROWING VISION WITHOUT LOSING SIGHT—DEVELOPING A PRACTICE STRATEGY

Adam Weinstein, MD
with edits by Michael Shapiro, MD
Can you answer these questions in regard to your practice?

Strategic planning

- Does your practice devote time to strategic planning?
- Does your practice consider the local market, its components, constraints and opportunities?
- What is workflow? How does workflow link strategy to operations?

The constraints of vision: market and practice resources

I was surrounded by floor-to-ceiling books. Sitting in the tiny office across from my college academic advisor, I remember staring at the spine of *Commentaries on the Peloponnesian Wars* when he asked me what I wanted to do with my life. What occurred to me was not the exact path from college to medical school to nephrology, but rather the vastness of the future. In theory, I could do anything. I had three more years to study anything I liked in preparation for any career I wanted. I just had to figure out what I wanted.

Similarly, when we started our nephrology practice in 2006, the future was vast and murky, but seemingly limitless. Initially, all we had were our values and ideas—delivering excellent patient care and good consultative services, and organizing nephrology care across our county and hospital system—to guide how we shaped our practice. During the first three years, however, it became clear that vision alone was not enough to guide our growth.

According to Michael Porter, strategy is the creation of a unique and valuable position involving a set of activities designed to focus on offering a specific range of services to a specific group of customers.\(^6\)

While having a well-run business is critical to achieving a successful strategy, making a business run well is not the endpoint of strategic planning. Thus, developing and refining a practice strategy is an ongoing process starting with a broad vision that

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guides the development of specific goals. Market opportunities and constraints, as well as the financial and human resources available to the practice, refine these goals. Goals are reached through detailed operational workflows. Operational workflows also aid in benchmarking progress toward stated goals and measuring success of achieving them. At the same time, the ongoing dynamics of regulatory constraints, the practice’s market, and practice resources require ongoing re-evaluation and evolution of the vision, strategy and goals. Developing a practice strategy is more than just a set of steps with a single end point; rather, it is a continual process that reflects the need to evolve medical practice in a changing business environment.

(See Figure 1.)

The values that guide one’s choice to enter medicine, perhaps the desire to aid patients or improve their quality of life, are often the foundation of a practice vision. Ours came out of many long discussions while we were in training. We found shared beliefs in the ideas that patients can and should be partners in their care, that preventative care in nephrology is important, and that physicians need to be one part of a broader care team. We decided to open a practice largely because we could not find an employer or existing practice who clearly shared our vision of what a nephrology practice could be like. Our abstract set of shared values has guided many of our concrete operational decisions. However, bringing this vision to reality has been a multi-step process.

If vision is the direction of the practice, goals are the desired endpoints of that vision. The most common goals in medical practice often pertain to the amounts of financial success, the volume and/or quality of delivered care, and various aspects of quality of life for the physicians. In an ideal world, physicians could deliver great care to a few patients, make a lot of money and go home early. As it is difficult to simultaneously achieve all of these ends, it is necessary to refine the goals to align with the evolving opportunities and constraints of the market as well as the available practice resources. Thus, it is imperative to understand what defines a practice’s market and how to think about a practice’s financial and human resources.

As with any business market, the medical practice market can be understood as having three components: the geography where the practice operates, the customers the practice serves, and the products and services the practice wishes to offer.7

The most basic of these elements are the business opportunities based on the location of the practice. The catchment area over which a practice has control or influence—to borrow a term from geopolitics—can be thought of as a circle with a certain mileage radius emanating from each office, hospital or dialysis center where a practice is located. The circle may overlap with other practices’ circles in areas where there is competition. What determines the radius of a circle is the degree to which a practice pulls in new patients. There can be natural barriers, such as bodies of water or mountains, or business barriers, such as a competing hospital or practice. These barriers will limit the influence a practice has over a given area and limit the flow of patients into the practice. In fact, each service or product a practice offers may have a different catchment radius. For instance, a practice may draw chronic kidney disease (CKD) patients from a 15-mile radius around their main office, but if it is the only practice with transplant nephrologists, it will draw post-transplant patients from a 40-mile radius. The dynamic nature of market conditions means that a practice’s market penetration will certainly shift with changes in competitors’ influence.

**Differentiating your practice from competitors**

A sound strategy will allow a practice to better ride the ebb and flow of these market shifts. For example, a new entrant suburban practice could decrease patient flow from an area at the edge of a previously uncontested area of

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influence. Strategy to differentiate one’s practice from its competitors will enable gains in, and maintenance of, market share. In typical medical practices, including nephrology, there are in fact three primary customers—patients, referring physicians and payors. There are other secondary potential stakeholders, including dialysis companies, hospitals, professional organizations representing physicians and patients, etc. Each group has its own definition of what constitutes “good” customer service. Patients typically want care that helps them achieve improved quality and quantity of life, time with a physician to explain medical procedures and tests, and a partner to guide them through the confusing medical landscape. They don’t want lengthy delays from referral to evaluation. Referring physicians also want timely care that complements their care for their often-times complicated kidney patients. Dialysis organizations for which nephrologists are medical directors look for clinical guidance and leadership. Payors demand precise documentation and claims submission, and in some circumstances they limit patients’ access to products and services the physician recommends. Managing the expectations of these stakeholders can create challenges to any organization, and nephrology practices are no exception.

Of the three aspects of a market referenced above, the easiest to define are the products and services the practice offers. Traditionally, nephrologists care for dialysis patients, perform inpatient consultations, offer outpatient CKD management, and provide clinical leadership in the form of medical directorships. More recently, interventional nephrology, post-transplant management, erythropoesis-stimulating agent management, clinical research and critical care have emerged as additional services provided by nephrologists. Each of these services should be thought of as a “service line” or “product” with defined overhead costs, time requirements, reimbursement peculiarities, government regulations, administrative and clinical goals, and varying customer demands.

In a free market system, businesses differentiate themselves to their customers using quality, service or price, alone or in combination. A classic example is jewelry. Tiffany’s caters to wealthy clientele, carries only expensive, very high-quality and unique products, and sells fewer items at higher margins than a typical mall jeweler, which focuses on providing “lower-end” products that cost less but appeal to a larger client base. One sells high-end, high-margin with very high personal service; the other presents itself as pretty much the opposite. Both have their places, even almost side by side.

In the case of nephrology practices, the Medicare Fee Schedule essentially determines prices, and most physicians are able to demonstrate an acceptable level of quality care. Therefore, how we differentiate ourselves from our competitors often boils down to service, or how we go about conducting ourselves day to day. This set of market constraints deserves serious consideration, as it represents the greatest business strategy limitations imposed on medical practices.

Since all nephrology practices operate by differentiating on service alone (sometimes unwittingly), other constraints to achieving goals must be looked at as well. When attempting to achieve a new or altered goal, the financial capacity of a practice, the upfront costs, the ongoing costs, the time to profitability, and the impact on cash flow must all be considered. For example, if a practice wishes to expand inpatient and outpatient consultative services to a new hospital and surrounding community, the addition of a new provider seems reasonable in concept. But associated costs must be considered, including salary and benefits, significant legal fees for contracts, a license for electronic medical records systems, changing office stationery, obtaining credentialing for practice privileges, and malpractice insurance. Also, there is often considerable delay between the time a provider starts seeing patients and when the first payments arrive, assuming all has gone on schedule with the credentialing process. This tally of initial costs, ongoing costs, and the expected time to profitability is important.

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Consider with this the impact on the existing monthly cash flow as it is reallocated in support of the expense of the new provider. As long as the goal of the new provider is to increase the total number of patients the practice is seeing—i.e., an expansion of service rather than replacing an existing provider’s services—there should not be a long-term drop in net revenue. The question, however, is how easily the practice can shuffle financial priorities until the increase in service and resulting net income is realized.

Thus, options for financing a new provider must be considered: Will there be loans, or a decrease in existing partner salaries, or salary support from some larger entity? Consider options for how to use the new provider to balance building the new colleague’s base of patients while generating no revenue for the practice. Options include having the new provider conduct some of the monthly hemodialysis visits, thereby freeing established providers to generate more revenue during the startup period. While simple, this example illustrates how a basic goal, such as increasing market share in a given area, requires asking and answering a series of complex questions that may alter the timing of, or the ability to complete, such a goal.

Using workflows to achieve goals
Goals must also be looked at in the context of a practice’s human resources, administrative and clinical capacity, and technologic infrastructure. Will the new satellite office generate call volumes that require more staff and/or new phone lines? Will the integration of a new provider generate more billing than the current personnel can handle? Will a new procedure require so much insurance documentation that the increased staff time overrides any potential net increase in revenue? How much time will be required for training the staff to use a new billing or document management system? What if the staff does not have the fundamental skills to learn a new system—a lack of technology literacy—to move to a paperless system? Could more dollars invested up front save greater expenses in time? For example, will a new phone system, which was the cheapest of the alternatives considered, accommodate connections to a planned satellite office? The capacity of providers needs to be assessed as well. Might advertising backfire if there is not enough provider time to accommodate the volume of new patient appointments? Will the addition of another dialysis unit require too much commuting or other drains on a practitioner’s time and/or quality of life?

Regardless of the apparently endless series of “what if” questions, the important thing to keep in mind is that any decision for change can have a ripple of unanticipated consequences if not planned correctly. Having a keen sense of the staff’s capabilities and good monitoring of the financial aspects of the practice will allow for goals to inform realistic operational workflows while keeping the strategic alignment in place.

Taking strategy from theoretical goals to successful implementation is the most challenging aspect of any strategic plan. Everyone in a practice, from the contracted janitorial staff through the most senior physicians, may be involved. Most importantly, goal implementation often requires a change to operational workflows, thereby altering how practitioners and staff complete their work. Resources must be dedicated to the people and systems that will enable a successful internal operation in support of the practice strategy. Consciously or unconsciously, all practitioners and staff use a workflow, the set of steps they take to complete a task. Though difficult, it is necessary to analyze the workflow, standardize it for efficiency and modularity, make work adjustments and retrain personnel.

We have found that the base unit of many medical workflows is either the patient or the patient’s data. For instance, in working through the steps needed to ensure we record all of a patient’s medications, we developed a workflow (See Figure 2) for medication management. Any specific task can be broken down to its component steps and then walked through like programming a computer. Each step in the workflow can be critically evaluated in terms of (a) resource management (Do we have the tools and are people properly trained to complete this step?); (b) primary responsibility and oversight (Who is to perform this step and why? Who
FIGURE 2

PATIENT REVIEWS RECORDED LIST OF MEDS DURING CHECK-IN

PATIENT LIST/BOTTLES COMPARED TO RECORDED LIST BY NURSING STAFF

OFFICE LIST UPDATED PRIOR TO PHYSICIAN SEEING PATIENT

UPDATED OFFICE LIST REVIEWED WITH PATIENT BY PHYSICIAN DURING VISIT

ARE DOCTOR AND/OR PATIENT CONFIDENT ABOUT OFFICE LIST ACCURACY?

PATIENT CONTACTED BY NURSING STAFF VIA PHONE AND MED LIST UPDATED OVER PHONE AFTER VISIT.

DID THE PATIENT BRING A LIST OR BOTTLE OF PILLS?

NO

YES

NURSING STAFF / PHYSICIAN UPDATE RECORDED MED LIST

CHANGES ARE SAFELY MADE
monitors the success of this step?); and (c) overall appropriateness (Is this step the best route to the goal, is it the best next step, and does it fit within and improve the likelihood of helping the organization remain true to its strategy?). The workflow also allows clinicians and staff to visualize their place in the chain of events leading to the realization of the goals. In our practice, portions of our Policy and Procedures Manual have been replaced with workflow diagrams. We publish workflows for comment prior to their adoption and often find new workflows posted at each workstation for quick, easy reference.

Well-defined workflows can be powerful tools in enacting strategy and achieving goals. Beyond ensuring all staff members are clear as to their role in the processes of change, workflows allow for benchmarking the implementation, measuring overall success, and facilitating further goal evolution. For instance, in the example of the medication workflow, one could use data from an electronic medical record system to track the date of medication list modification versus appointment dates to measure the frequency with which patients are having their medication lists updated before and after implementation of the workflow. Other practical, realistic outcomes to track with this workflow are the frequency with which patients report that their most recent medication list is incorrect on subsequent visits, or the number of times nursing staff must phone a patient to update a medication list.

Utilizing workflows also facilitates easier transitions in times of change. Changed workflows will be visually represented and staff will have a good starting point on which to base changes in their work patterns. Workflows provide “built-in” points for measurements and allow physicians and staff day-to-day as well as long-term markers of progress.

Unfortunately, the successful implementation of operations or workflow does not mean that a practice strategy will be successful. Again, operational excellence is critical, but it’s not a strategy per se. The practice’s leadership must closely watch for changes in the market, new entrants who will compete with the practice, or new financial constraints and/or other barriers that could alter the feasibility of reaching previously stated goals. For example, the emergence of a new medical technology that allows nephrologists to treat a new group of patients can dictate a change of course, such as small devices for pure ultrafiltration at bedside for heart failure patients. Conversely, when the credit markets were contracting in the winter and spring of 2009, we found that our business line of credit was not renewed and we were given a lower limit on our business credit card. Almost overnight, an ongoing IT goal that called for the purchase and implementation of new hardware was slowed since we could not afford as much equipment each month.

The most common—and nerve-wracking—causes of goal reevaluation and workflow alteration are regulatory changes. When CMS changes the nature or the requirements of a given service, a practice may have to change the workflow for how they handle documentation, the financial outlook for a given service they provide, and possibly generate new workflows for some form of self-auditing.

**An active mind is prepared for change**

In these events, success depends on practice leadership being responsibly active-minded and forward-thinking, always testing the emerging events against current goals and intervening to avoid downstream problems. It could be argued that this anticipation and responsive action is really what sound practice management and effective practice strategy is about. The articulation of goals for creation and sustenance of a successful differential advantage, and the subsequent development of operational workflows, constitute the intellectual framework needed to support successful practice leaders as they guide the organization through the changing world of medicine.
MODULE 3
SPEND TIME FOR EFFECTIVE
DECISION MAKING

Tim Hines, MD
with edits by Paul Turer, MD
Can you answer these questions in regard to your practice?

Decision making

- Should decisions be made by consensus or majority rule?
- How often do the physicians of your group meet? Who shows up? Do you accomplish your goals for the meetings?
- Are your meetings too frequent, too infrequent, poorly attended or over-attended? How are the meetings run? Is there an agenda and, if so, do concrete decisions result? If not, what is the group doing about it?

This section will serve as a template for developing an effective strategy of decision making in a medical practice. It is important to note that while Governance and Management set the overall goals and strategy for a practice, it is decision making that allows the group to carry out Governance and Management prerogatives.

Darrell K. Royal once said, when explaining why he eschewed the forward pass, “Three things can happen when you pass and two of 'em are bad.” Similarly, when we set out to make a decision, three things can happen and two of these are bad. We can make the right decision, we can make the wrong decision, or we can fail to make a decision. Failing to make a decision is the worst outcome of the three, because even when we make wrong decisions we have the opportunity to learn from them. The following are guidelines that can assist you and your practice in making good, well-reasoned decisions that will help you reach your goals.

There are many things to consider when a group makes a business decision. Competing interests, time constraints, and different value systems are impediments to making sound decisions. A governance structure can assist your group in making considered, timely and ultimately successful decisions.

The first issue to consider is how decisions are made within the structure of your practice. Many groups have multiple physicians covering many dialysis units, hospitals, access centers and offices, all of which compete for a physician's time. When decisions need to be made, impromptu meetings are sometimes scheduled to discuss the issue. These meetings can be poorly attended or cancelled if a practice does not have a formal structure for decision making.

One common scenario occurs when a practice needs to make a quick and often reactive decision. Often, a crisis demands a meeting. The meeting’s agenda is centered around the major decision to be made and for less-important decisions as time permits. With no algorithm for decision making, physicians often talk in circles and may or may not make a final decision. Great ideas occasionally emerge, but are poorly followed up. This experience teaches us that the most important aspect in carrying out decisions is having a formalized structure for decision making in place.

One way to institute a formalized structure for decision making is to instill a management committee in the practice. This committee will be responsible for designing a template for decision making that would be finalized by the practice. Management committee members optimally serve staggered terms (e.g., each for three years), and after each term the committee member must “sit out” one year to ensure wide participation by the group’s partners. Also, the physician president, or managing partner, has a permanent seat on the management committee unless otherwise removed. This committee should also include administrative staff (practice manager and clinical manager) who would be non-voting but provide needed information. The meetings should be open to any others who wish to attend. Younger associates should be encouraged to attend to better understand the practice processes.
Running meetings requires skill, and this should be pursued by leadership. Seminars are available to assist here. Staying focused and on time will help all involved feel they are being productive. Assigning tasks appropriately and providing resources is critical to gaining the confidence of the group.

Management committees are empowered to make certain decisions without approval of the entire group. Provisions are made for decisions that require a simple majority vote of all the partners. Some examples of these decisions include:

- Election/removal of management committee members
- Approval of associate physicians for shareholder status
- Budget approval
- Approve large single expenditures not in budget
- Approve loans
- Approve strategic plan developed by management committee
- Approve substantial changes to physician call/vacation
- Approve significant changes in physician compensation models

Management committees, with the president or practice administrator creating the agenda and chairing the meetings, should meet at least monthly (weekly in busy practices) to keep the agenda moving forward. It is essential to have an agenda with action items, responsible parties and time frames to ensure that these meetings run efficiently. The management committee should make decisions via a simple majority vote; however, on more sensitive issues there ought to be a more substantial carrying requirement. Alexis de Tocqueville coined the term “The Tyranny of the Majority” to point out the problems with a simple democratic rubric. Critical issues may, therefore, require a supermajority vote to pass. Some examples of issues requiring a supermajority vote (75%) include:

- Approve acquisition, merger or significant corporate reorganizations
- Amendments to the mission statement
- Approve material changes to corporate documents: shareholder-physician employment agreements, shareholder agreements
- Determine involuntary withdrawal of a shareholder

Minutes of these meetings should be provided to the practice at large for review and comment.

There are many other elements to a governance and management plan, but this basic approach will allow practices to proceed forward in the development of a comprehensive decision-making structure. Once the process starts, it will unfold as it needs to in your particular practice.

Once in place, a decision-making structure will allow a practice to move forward on many fronts and position itself for success. Practices will be able to realize opportunities that they have been contemplating for years, but on which they were never able to act. Not every decision that a practice makes will prove to be the correct one, but it will enable growth and learning.
While the rules of governance help, they do not make decisions by themselves. You may find that an algorithm will help, as in H. W. Lewis' book *Why Flip a Coin: The Art and Science of Good Decisions* in which he suggests the following:

1. List possible actions.
2. List possible consequences and the utility of each consequence.
3. Evaluate the possibility that each action will lead to a given consequence.
4. Choose the action that has the best expected outcome.

It is very important to establish the ultimate goal(s) of any particular decision. For instance, is the goal increased market share or better quality of life? These goals are often at odds in medical practices, as most physicians want both. To address these and other issues, practices need to develop a formalized strategic plan (discussed in more detail in Module 2). For example, as noted above, many groups elect a managing partner or president who becomes a “permanent” (while in office) member of the management committee. The managing partner might then be responsible for working with practice staff to help bring to fruition the various projects and goals agreed upon by the management committee. This is the root of strategic alignment discussed in more detail in Module 2. The entire group may also find it helpful to meet monthly to review progress and to give feedback to the management committee.

These things take time if done correctly, and members of the management committee must be compensated for their time. There are a few ways to compensate for management time. In an equal income distribution compensation model, a reduction in clinical duties should be sufficient. In a productivity model, cash compensation is necessary. Many groups try to accomplish goals without management compensation, but for obvious reasons, this tactic usually fails.

The mission and vision statements (see Module 1) along with the practice’s strategy and goals (see Module 2) provide guidance for effective decision making. Possible business ventures should not be pursued if they are not consistent with the practice’s mission and vision. The mission and vision statements should be developed with input from all shareholders to assure buy-in by all physicians. In addition, a practice “compact” should be developed, which explicitly states what physicians can expect from the practice and what the practice expects from its physicians. This will help avoid misunderstandings and lead to greater collegiality and teamwork among the physicians. Open communications and transparency also foster teamwork and collegiality. Having shareholder meetings three or four times a year, where everyone is updated on important operational and strategic issues, will also help the practice function as an effective team.

One last important concept in decision making is the idea of “Founder’s Rights,” or pre-conceived notions by the founding partner. Many practice founders feel that because they started the group, developed relationships with referring physicians and opened dialysis units, that they deserve a certain amount of power and respect from new associates and partners. Practice leaders will quickly learn that these things have little value to younger associates, who are most concerned with growing the practice. Once a leader accepts this reality, the group will be able to focus its resources and energy on more important issues.

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MODULE 4
HOW TO PRODUCE CHANGE

Chris Hebert, MD
with edits by John Robertson, MD
Can you answer these questions in regard to your practice?

Producing change

- Who is responsible for initiating change within your nephrology practice?
- How is change best carried out in a nephrology practice?
- Why is change necessary in a nephrology practice?
- What are your barriers to change?

Sponsoring change in a practice

1. Types of change.
   a. Planned
   b. Reactive
   c. Crisis

2. Creating a culture for change.
   a. Identifying capable leaders
   b. Eliminating hierarchy
   c. Implementing openness to change

3. Discovery of change that is needed.
   a. Change in focus
   b. Change in culture
   c. Change in process

   a. Creating objectives
   b. Carrying out objectives

5. Forces of change.

Outside forces such as government health plans, reimbursement cuts, billing and coding changes, and employee benefits are examples of things that will continue to force change upon us, regardless of our preparedness and/or willingness to adapt.

Change is difficult. Organizations continue to face challenges related to transitions of all types. Any group of individuals, whether government, a bank, a corporation, or a medical practice that intends to remain viable, has to face the challenges of change and develop a strategic plan to implement change when the time calls to do so. There are many pitfalls to being overly rigid and inadaptable, as flexibility is needed to handle the diverse range of pressures that demand and drive change.
In Spencer Johnson’s classic book on change, “Who Moved My Cheese?” he includes a series of succinct admonitions, entitled “The Handwriting on the Wall,” which we think warrants our attention. It states:

- Change Happens–They Keep Moving the Cheese
- Anticipate Change–Get Ready for the Cheese to Move
- Monitor Change–Smell the Cheese Often So You Know When It Is Getting Old
- Adapt to Change Quickly–The Quicker You Let Go of Old Cheese, The Sooner You Can Enjoy New Cheese
- Change–Move with the Cheese
- Enjoy Change!–Savor the Adventure and the Taste of New Cheese
- Be Ready to Quickly Change Again and Again–They Keep Moving the Cheese

Some change can be foreseen and planned for. An example of this is the case of a successful practice looking to expand into a new geographic area. At other times, change may represent a response to some event, like the emergence of a competing group, reductions in revenue, or increases in practice overhead. Crises, such as the unexpected death or retirement of the group’s leader, may require an urgent need for change. All of these types of change are dealt with similarly if there is a culture of adaptability within the organization. A culture of adaptability derives from the group’s leadership, also typically its change agent(s), and moves through the organization through its vision, mission, and governance-created balance of power.

So what do we mean by “change agent?” Since change often requires some work from all participants, or even perhaps a real shift from what may be in each participant’s comfort zone, there has to be a “case for change.” Those who ask an organization to change need to make a clear case for change. A compelling justification that answers the question, “Why change?” is needed. Tension for change should describe the impact of not changing, or the resulting negative impact to the organization’s mission, vision and strategy from failure to change. If we are only partially fulfilling our mission and goals now, how will a change improve our group’s likelihood of a more successful outcome? Of course, change may help produce a positive result (e.g., we make more money and provide better care) or avoid a bad outcome (e.g., greater liability with what we currently do, or higher risk of adverse outcome from lack of compliance with a government regulation). Inherent in this discussion of why we should change is “What will it really take to change?” Very few of us have any real training in our nephrology education that prepares us to answer all the tough process questions, like:

- What will change cost?
- What are the steps involved in organizational change?
- Who will be affected?
- Are there acknowledged measures and established benchmarks of success available for us to use as our guides?
- What will be the major challenges in tackling change?

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As Silversin and Kornacki state, “The starting point of a change process is creating and aligning a team to launch the effort and oversee it through completion. The team consists of individuals who play three distinct roles: sponsor, agent and champion.”

- Sponsor—this is usually the leader of the organization who identifies that a change is required
- Change agent—this is not always the sponsor, but may be a team member, like an internal consultant, who has detailed knowledge of the people and processes essential to what is being changed
- Champion—this is an opinion leader across the organization who is often an early adopter, one who embraces change and facilitates change within the organization

Note: In small practices, a leader may assume all three roles.

Some physicians choose to employ a governance structure; i.e., a hierarchy of decision making, based upon age and organizational tenure which, unfortunately, does not necessarily identify the correct person to whom such a leadership role should be entrusted, someone with the skills required to lead the group through a dynamic market. Such rigid and potentially ineffective hierarchies within an organization make it difficult to implement change due to the lack of collaboration needed to adjust and adapt to external forces.

Balancing leadership with followership is discussed further in Module 5, and is relevant here. Effective change agents are needed from both the medical/physician and administrative arms of a medical practice. Whether a senior physician partner or a new medical assistant, sponsorship and acceptance of change will be easiest in groups where leaders are identified (often self-identified) and given the opportunity to succeed. Often leaders are chosen, other times elected; in some practices, leadership may be a position by default. The characteristics of the best leaders within a practice are those who have the ability to be flexible themselves and to encourage flexibility in others; to influence and motivate others within the organization; to respect the opinions of others, and to effectively delegate responsibilities and enlist others for change implementation. It is not necessary for the change agent, or even the champion, to be the sponsor or even a physician in the practice. Ideally, leaders are identified at all levels of an organization, whether a part of billing, research or human resources. If more of these individuals are enlisted to actively participate in the design and implementation of the required changes, it is more likely that meaningful buy-in will occur, as change tends to affect everyone who works there, regardless of their role. Identification, recruitment and empowerment of such leaders begets greater adaptability in all parts of the organization.

While a rigid hierarchical governance structure makes decision making easy (as in an autocracy), it can be viewed as overly dogmatic—particularly in larger organizations—and can actually increase barriers to change. Assuming that the practice’s employees (including physicians) are employees at will, free to go elsewhere if they choose, change requires buy-in. When change is simply mandated from the top, it can be met with complacency and/or lack of participation in the new process, perhaps due to a lack of understanding of the purported need for change. Groups with a less rigid structure encourage their partners and other employees to feel like they are an important part of a collaborative effort when it comes to embracing change. Those with a voice in the changes taking place are more likely to see them all the way through.

The leaders within a group will ideally create a culture within their practice that identifies the need for adaptation and motivates people to change. This culture ideally encourages collaboration and eliminates complacency and indifference. As discussed in Module 1, such a culture is more likely to be imbued via a well-thought-out mission, vision, and an organizational structure that effectively utilizes every employee’s skill set to its potential. The strategic alignment is discussed in more detail in Module 2.

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What else can you do if the planned change is of a large scale or involves significant risk to the operational integrity of the organization? One approach is to “pilot” the change in just part of the organization, learn from the process and refine a rollout when it seems likely there will be a predictable outcome. To have an effective pilot, there must be a clear definition of what and where this pilot is to occur. Its outcome cannot be known unless appropriate measures of outcome are anticipated and measured. There should be group agreement on the measures and their meaning. Once initiated, the credibility of the whole process is enhanced if the process is regularly scrutinized and refined.

Anticipating and planning for resistance to change is part of the change process. Remember, everyone is for change as long as it doesn’t affect them! The key to breaking down resistance is to move beyond a sales pitch for change, to data supporting the need and process for change. In fact, it is helpful to include some of those who have expressed doubt about the need for change in this pilot process so that they not only have their voices heard, but can address some of their direct concerns about the change. Be sure to “celebrate” and recognize those whose effort made the pilot a success. The future effort involved in a successful rollout, including confronting and successfully negotiating any remaining change barriers, requires as many as possible “on board.” In our evolving culture, it is becoming commonplace to employ physicians who, due to concurrent family responsibilities, want to work part-time. Also, a variety of patient care responsibilities are now being relegated to nurse practitioners and physician assistants. Moreover, a greater diversity of ethnicities and beliefs are more commonly being encountered and incorporated into our practices’ cultures. Needless to say, adapting to such diverse needs means that medical practices, just like other organizations, are likely to benefit from a willingness to adapt, and thus take advantage of the opportunities that can accrue to the practice from such change.

Additionally, change may be needed when it comes to processes, which affect all employees of a practice. Process can be affected in many ways. Many practices are changing to electronic medical record keeping, electronic prescription writing and electronic billing. Other practices will decide to change a compensation model or call schedule (see Module 6).

Regardless of the tension for promoting change, if the leadership and culture for change are in place, then all of these things stand a greater chance of being handled effectively. Remember, for resistance or for barriers to be overcome, the leaders need to embrace change first and help the rest of the organization let go of its current expectations. An explicit acknowledgement of this is often required and requires clear communication. One method often employed is to “create a success story” where the issue has been addressed in another organization facing the same change. A description is provided as to how this change was pushed through, and the end result.

Each type of change will require a plan with goals and objectives. The communication, management and implementation of that plan will be what constitutes the final change within a practice. A change plan should be easy for everyone in the organization to see. It should be easily communicated. It should be flexible, so that everyone affected by the change will have a voice. Examples of process objectives include:

- “We want to reduce overhead by 10 percent this year”
- “We will bonus physicians based on productivity in the following manner…x”
- “We will go live with an electronic medical record on January 1”

A focus plan may be:

- “We are going to grow our chronic kidney disease clinic by 50% this year”
- “We are going to franchise our practice in other states”
Examples of a culture change objective may be:

- “We are going to hire 25% bilingual employees this year to serve our growing demographic of non-English-speaking employees”
- “We are going to recognize all religious holidays in the organization”

These objectives will be malleable and discussed in the organization, so that all individuals are empowered and will embrace such changes.

Change will be necessary. “They keep moving the cheese.”\textsuperscript{12} Both success and failure within a practice drive change. Both growth and downsizing also require different types of change. The organizations that have identified effective leadership and created a culture that embraces change will be best suited to handle the adversity related to all types of change. At that point, change can ultimately be institutionalized within the organization and left as an example for the next set of challenges that lie ahead.

Vignette for the change module

The following represents an interview process that demonstrates how a practice leader can prepare a candidate for change in a practice, and how the practice leader explains to the candidate that he will be responsible for participating in the change process.

Dr. Sermon interviews a fellow, Dr. Trapani, for entry into his practice.

Dr. Sermon: Welcome to our city! In this part of your interview process, I would like to go over what you can expect from our practice and what our practice will expect from you if you join us.

Dr. Trapani: Well, I think I pretty much know what you would expect from me. You would like me to take care of the patients that I am assigned and take my share of hospital call. I assume you will give me the autonomy to practice as I see appropriate.

Dr. Sermon: Yes, we do expect that you take care of the patients, do call, and we certainly agree, due to your training, that you should have relative autonomy in taking care of the patients.

Dr. Trapani: What do you mean by relative autonomy?

Dr. Sermon: I will explain what I mean by relative autonomy in a few minutes. We do have other expectations of our associates that relate to the success of our practice.

Dr. Trapani: For example?

Dr. Sermon: The vision for our practice is to be the best nephrology practice in our community. We cannot do that without working as a team in our practice. As a team player, each nephrologist is expected to participate in the development of the practice as a business.

Dr. Trapani: I must tell you right now, I did not have any business courses in my training curriculum. I don’t know if I can add any value.

Dr. Sermon: No, no (laughing), I am not talking about textbook business responsibilities here. We ask every associate to help the growth and reputation of the practice by participating in our weekly meetings and agreeing on courses of action that collectively make us a stronger practice. For example, we might decide on how to cover call at the main hospital here such that we respond faster than our competitors. We might have to make some decisions on how we operate, like rules around when to call for help from your partners to make sure that we can respond quickly, and that might affect all of the doctors in the practice.

Dr. Trapani: Oh, I get it. Are there other things that I need to know?

Dr. Sermon: Well, we are currently developing a mission statement and developing some core values for the practice, both of which will help us define how we want to operate and take care of patients.

Dr. Trapani: What is a mission statement? I think I know what core values are, but what is the practice thinking?

Dr. Sermon: The mission statement should be the general purpose of our organization, why we exist.
Dr. Trapani: Isn’t that obvious, to take care of kidney patients?

Dr. Sermon: Yes, but how should we take care of them? Do we want to do this so well our patients will never go elsewhere for kidney care? If so, how do we define our mission such that this occurs? For example, if we decide that our mission statement should reference taking care of our patients in a dedicated, caring environment, do we let them wait for over an hour in our office waiting rooms before they see us? How should we operate differently to fulfill this mission if, after we measure patient waiting, it is on average greater than one hour? All of our office staff should know how we want to take care of patients, too. They are our ambassadors, so giving them the mission statement can be a plus for our practice. In fact, we should cultivate a culture that allows all our employees to feel they can make an impact to help us be better at fulfilling this mission.

Dr. Trapani: You said you were developing some core values for the practice.

Dr. Sermon: Yes, there are behaviors that we should expect of each other in the practice.

Dr. Trapani: In addition to taking good care of the patients?

Dr. Sermon: Of course. One of the things we consider very important is professionalism. We are highly visible in our community. Inappropriate behavior, whether it is in the hospital, office, dialysis center or even in your neighborhood, reflects upon the practice. Another is integrity. We must trust that each of us is honest with each other and all those with whom we interact.

Dr. Trapani: Are there any other core values that I should be aware of?

Dr. Sermon: Yes, we value a positive work-life balance very highly here. Rather than having our associates become tired and burned out, we insist on taking vacation and enjoying life outside of work. We’ve found that this creates a healthy work environment, increases enjoyment at work, and we work harder.

Dr. Trapani: So that is why your practice seems more generous than others in the time you give off?

Dr. Sermon: Yes.

Dr. Trapani: I like that. If you have all of this in place, then the associates are in a very stable environment, I would assume.

Dr. Sermon: Stable in terms of knowing what we stand for and how we behave. On the other hand, environmental forces quite often dictate that we change our activities and things we do in our practice. Our vision statement, with the soon-to-be-added mission statement, gives associates in the practice direction on how to react to changes in the market. For example, let’s say our mission is to give our patients the best care. And we have two competing cardiology groups in town, one providing excellent care, and the other doing what we would consider as too much aggressive invasive work. Due to our mission, we could decide to refer most of our cardiology patients to the group that does not do an inordinate amount of invasive work. This is what I mean by relative autonomy. We decide as a group to refer mostly to one cardiology group, but the individual nephrologist in the practice is still free to refer to the other cardiology group if he or she determines that is the right thing to do for a particular patient.
Dr. Trapani: That makes sense. Thank you for the clarification. Are there any other things about your practice that I should know about?

Dr. Sermon: Yes, one important quality that we stress here is the ability to deal with change. A few years ago WKA merged with another practice. The two groups had differing views on many things such as call structure, adequate presence in the dialysis facilities, presence in the hospital, values and work-life balance. When the two groups merged, we faced some difficulties in aligning our thoughts and goals. Fortunately, the groups overcame these differences and now the practice is operating at a very efficient level. That being said, we look for associates who accept that change is good, and often necessary when the practice experiences changes.

Dr. Trapani: I understand. Are there other business factors that I need to know about?

Dr. Sermon: Yes, we all participate in some way in helping our practice grow. For example, Dr. Beeman is responsible for establishing, maintaining and training on our EMR. Dr. Rogers is responsible for developing our CKD clinic. Neither one of them had any business courses in their curriculums. Dr. Mason is responsible for payor contracting and working with the IPA in town. He never thought of having to bring money into a practice prior to joining us! Dr. Germain is key in regard to our making inroads at the hospital on the east side of town. Each of us has had to learn our additional responsibilities from square one; now we embrace the fact that each of us brings knowledge about different aspects of the practice to the table.

Dr. Trapani: OK, I get it. What would you have me do if I joined the practice?

Dr. Sermon: Well, we can discuss that later today, taking into account our needs and what you would like to do. First let me introduce you to others in the practice.

Editor's note:
In this interview process, Dr. Sermon is purposefully preparing the candidate for the following:

• The expectation that the candidate participate in the practice beyond just caring for patients
• The expectation that the candidate should buy in to the practice mission and core values
• The expectation that the practice will change in response to changes in the environment

Dr. Sermon should be noting the candidate’s reactions to his comments. If there is understanding and acceptance, the candidate may be a good fit for the practice.
MODULE 5
REDUCING PRACTICE DISCORD

John Maynard, MD
with edits by Paul Turer, MD
Can you answer these questions in regard to your practice?

Reducing practice discord

• What are the characteristics of effective leadership, and how can leadership produce and foster followership?
• How do these characteristics help to reduce discord within the practice?
• What is the best way to hire the right physician for your practice?
• What are some of the ways to promote effective communication within your practice?

Avoiding or reducing physician conflict

Before getting into the details of this chapter, we would like to first comment on some basic attributes of leadership in a practice. Without confident, self-assured leadership a practice can never thrive. Leadership is not determined by the number of gray hairs you have! The sooner this is realized, the better. Senior partners without leadership skill are often much better councilors than strategists.

As we all well know, the strongest leaders lead by example. There should be no special perks, privileges or treatment. Yes, their time may be compensated as needed, and they may have a larger office if it is necessary to entertain clients to do the business of the practice, but anything additional should be easily explainable to the practice that supports it.

Leaders should be strategic thinkers, organized and selfless. They should consider the short- and long-term impacts of where they lead the practice for all involved. They should be personable and politically savvy. Skills of collaboration and inclusiveness are key. Goleman identifies these and other attributes as part of one’s “emotional intelligence.”

They should be problem solvers, patient and goal-oriented. They should have skills to run meetings and be sensitive to developing and following transparent processes.

Most of all, they should seek to develop the unique skills in each of the other members of the practice, including the administrative staff. Importantly, they should develop a succession process (you shouldn’t lead until you die) so that the practice, not their ego, is preserved.

We all know leaders when we see or hear them. Seek them out and let them lead. Work with them. Develop success matrices for them. Your practice will thrive!

Now to the details…

1. Lay the foundation by hiring the right doctors.
Getting the right people into the practice may be the single most important thing you do to promote harmony. Listen to the physician candidate and references, asking yourself, “Is this doctor a team player?” Have a prepared set of questions:
• “What geographic area are you interested in?”
• “What accomplishments are you most proud of?”
• “What would peers and nursing staff say about you?”
• “What would an ideal practice look like?”
• “What does work/life balance mean to you?”
Explain the group’s mission, vision, values, culture and rules to the candidate so that later you can say, “Remember what we explained about our group?” Don’t expect the candidate to self-select based on this, as it’s common for applicants to say what they think the interviewer wants to hear. Meet with the new associate physician shortly after starting and take the opportunity to give and receive feedback. Point out what is going well and what is not going as well. If there are significant issues, give this feedback in writing: What have been the problems? What needs to change? Meet again at six months, at which point–like a fistula at six to eight weeks–you had better see maturation or something needs to be done!

2. **Practice nephrology as a group.**
   In our opinion, this is the second most important means to avoid or reduce conflict. There should be an organizational mission, vision and set of values. Develop a “compact” for the group. What are physicians expected to give? What will physicians get? Expectations must be explicit.

   Effective governance of a group, how it makes decisions that affect all of its individual physician members, generally dictates that group policy should be determined by a majority vote. That’s the key point of group culture: decisions are made as a group. Each physician should be heard, but does not have a veto! We’ve also found that having a group sign-out adds to our cohesion. At the end of each week, the physician should sign out by email (assuming suitable encryption to maintain HIPAA compliance) for the other physicians to pick up the patients. This might be the weekend coverage, or the whole week, or the dialysis unit. We send the email to every provider in the practice, including our nurse leaders. This accomplishes a number of good things:
   a. The clinical information is passed on to the next doctor.
   b. The clinical information is communicated to the previous doctor, to see what exactly happened to that patient they admitted, or saw at night, or did not see at night.
   c. Peer pressure kicks in, just like morning report. The manner of clinical practice becomes more similar. Wide variability in clinical practice, where established guidelines and/or protocols exist, is not desirable; this helps to ensure consistency and better outcomes.
   d. This process of communication to all provides transparency; individual phone calls and transfers of lists do not.

3. **Everyone’s schedule and compensation must be fair.**
   We’ve seen groups that do not keep call records, where some person has had more holidays and weekends assigned than others. Consider publishing a list showing the details of the schedule so the statistics are clear and transparent. Work should be distributed to meet the needs of the practice and maximize physician efficiency. Also consider rotating various practice assignments, even if not equally, so each person has a taste of what that area is like.

   A discussion of compensation models and options can be found in Module 6. Productivity should be monitored; equalization of workload is especially important in an equal income model. A pure production-based compensation model is an option but also has its challenges.

4. **Communicate in an effective and healthy manner.**
   A company newsletter may be a good way to keep everyone informed.

   Having regularly scheduled physician meetings, each with a defined agenda, improves communication and serves as a vehicle for sharing ideas among group members.

   We encourage our physicians to talk directly to each other when they have disagreements. The staff looks to the physicians to be leaders. They want the partners to work together to best serve the mission. It is the job of
management to translate the group’s strategy into effective operational workflows that support the viability and esprit de corps of the practice. Regardless of whether a physician or non-physician is identified as the practice’s manager, it will be this person’s task to take guidance from the practice’s physicians and develop and explain practice policies and procedures to the practice’s support staff. It will also be imperative for the physicians to support these processes so that proper execution is most likely to result.

**Summary:** The best defense against conflict is transparency and preparation. The managing partner(s) can do much to avoid problems by actively encouraging the culture, policy, incentives and schedules consistent with functional relationships and healthy outcomes. Transparency is the key—lay everything on the table. Just as good patient care is about communication and the doctor-patient relationship, good practices have good communication and relationships among the physicians of the practice.
MODULE 6
HOW TO EFFICIENTLY AND EFFECTIVELY UTILIZE YOUR RESOURCES

Stuart Senkfor, MD
with edits by Michael Shapiro, MD
Can you answer these questions in regard to your practice?

Resource deployment

- Does the group have a physician performing administrative duties? Is this physician performing the duties at a high level? Is this physician compensated for their time and, if so, how?
- Do you plan to provide avenues for reduction in weeknight and weekend call coverage for physicians who wish to opt out?
- What are the critical elements for effective utilization of resources?
- How does compensation reflect the priorities, values and overall success of the group?
- What are the challenges in creating a work reduction compensation formula?
- How does your practice assure workload and compensation are equitable?

Orientation

Prior to making decisions about optimal utilization of a practice’s resources, it is important to first identify what those resources are. The obvious ones include equipment, databases, access to capital, and goodwill. Sadly, we often forget or minimize ourselves and colleagues as a resource. We are fairly quick to criticize or judge one another or to create very strict rules to contain and manage physician behavior.

In addition, we spend great amounts of energy trying to regulate, monitor, motivate and prevent variations from the mean. For example, the mere mention of reducing one’s workload, in particular on-call responsibilities, sends shock waves throughout a group. I would suggest a different road. Since we all have different strengths (e.g., clinical, based upon training such as transplant, research, leadership and/or management skills, etc.), it seems logical that our job duties should not be exactly identical. Individual physicians need to be cultivated and given flexibility that will allow the physician to blossom into a major contributor to the practice in the financial, motivational or medical arena, adding tremendous value, cohesiveness, diversification and esprit des corps.

This process starts on day one. As a new physician enters, he picks up quickly on what is expected, how the practice’s doctors communicate, how work is distributed; he hears all the undertones and grumblings which add to his own frustrations of not knowing where to go, whom to call or how to get things done. The orientation process for new physicians will likely have a major impact on efficiency and performance in the first six months (and perhaps also long-term) and will play a hand in the emotional health and professional satisfaction of that new partner.

Although we want the new doctor to be productive from the outset, all organizations benefit from investment in an orientation process prior to turning a new employee loose and having them work independently. The larger the group and the more hospitals or clinics, the more likely the orientation will be complex and detailed. Orientation should include introductions to the office staff, office operations or workflow (see Module 2), critical phone numbers, referral patterns, dictation and/or EMR orientation plus cafeteria and parking options (and let’s not diminish the importance of bathroom locations!).

Although just quickly mentioned, phone numbers are critical. Having a handout or an electronic version of the top 25 numbers will save huge amounts of time. Also important is an orientation to billing and coding. Although the coding and reimbursement system is flawed, challenging and ever-changing, it is critical to have each new physician be in compliance with CMS’s documentation/coding requirements. In addition, it is important to orient the new physician to parts of the practice that are not directly germane or even very tangential to his or her daily duties. Although initially counterintuitive, this will provide a greater sense of the scope and complexity
of the group, allow valuable time with other physicians in the practice, and convey a sense of transparency and camaraderie. Secondly, on-call responsibilities might best be deferred until this initial phase of the orientation process is complete. In our practice, that’s three to four weeks of no nighttime or weekend call. We’ve also found that for the first several call nights, a second resource physician should be assigned for any questions or problems encountered as a consequence of simply being new. Finally, we all need to recognize that a successful and complete orientation is roughly a six-month process. Positive and corrective feedback is very effective early on, and should be formalized. Any problems that arise should be dealt with quickly and professionally. The manner in which the more seasoned physicians in the practice handle such issues at the outset will likely determine how new physicians will interact with others in the future. The initial experiences, whether or not the result of a successful orientation process, will plant the seeds for how the new physician will treat the office staff, fellow physicians, interviewees and the next hire. Our practice incorporates a formal Periodic Performance Review after six months of employment and then annually for all physicians in the group. It is not only completed by fellow physicians but by the supporting staff, administration and billing departments. Patient satisfaction surveys could also be factored in.

Orientation summary:
1. Set aside a generous amount of time for orientation.
2. Orient the new physician to the hospital, office, clinics, referral patterns, EMR and internal practice management.
3. Supply the new physician with a list of critical and useful phone numbers, addresses and clinical electronic application logon credentials.
4. Orient the new physician to your practice’s billing/coding compliance program.
5. Expose the new physician to the full scope of the practice with enough time to gain an appreciation for each aspect.
6. Create backup for the new physician during the day and for call until enough logistical experience has been gained.
7. Ask for and provide constructive feedback at one month and six months, at the very least. If a problem arises, address it immediately and do not wait for the scheduled feedback. We find that a formal review/feedback process is helpful.

Compensation
Each practice has its own compensation formula and associated strategy. While there is no single correct or ideal formula, it’s important to acknowledge that there is an underlying truth when it comes to paying ourselves: Compensation directs behavior. If increased productivity is the goal, then base a portion of compensation on production. If it’s a goal to establish better customer relationships, then have a bonus structure factoring in such behavior. If a goal is to foster physicians in the practice helping fellow physicians, then perhaps cut the profit pie equally to incentivize cooperative behavior.

Before designing a compensation model, reflect on the group’s mission, vision and values, the desired culture of interaction and cooperation, what behaviors to emphasize or minimize, and what the workday and work week should look like. Individual incentives should be simple to understand; there should be a short lag time between performance and reward; it should be substantial enough to matter (>20%), and should evolve as the practice evolves. Bonus models tend to fall into six categories: productivity, utilization, cost, clinical quality, patient satisfaction and group participation.

Should compensating formulas be identical for each physician? If not identical, then it had better be highly defensible why one person is compensated differently than another. Secrecy around compensation is ultimately impossible. How does one deal with certain job assignments being inherently unequal either in volume,
reimbursement rate or stress level? How should a strategic area of the practice that may be unequal in revenue generation be addressed? What about efforts to grow into a new area with uncompensated time used to develop new referral patterns? This is a complex area.

The compensation model needs to be flexible enough to create an environment of fairness, motivation and entrepreneurialism. It needs to allow a practice to grow and try new ventures. The compensation model is perhaps not best designed to reward an individual’s efforts over the group’s needs, nor to be a payment for “goodwill.” It should probably not be designed to reward the seasoned over an equal but younger partner. Compensation is a tool, but it may also be a weapon or a grenade. If handled poorly, without characteristics such as a sense of fairness and equity, it will cause dissent and dissatisfaction. If handled well, it will create camaraderie as well as a sense of fairness that will extend beyond those being compensated to non-physicians, referring physicians and patients. Fair compensation will pay off over the long run far better than any model deemed heavy-handed or lopsided. My sense from our own group’s experiences suggests that when in doubt, it is better to err on the side of being “overly fair” than to be perceived as stingy or contemptible.

Not commonly discussed is how to compensate for practice management time. This type of work is very different from medical work and, if properly valued, can yield many benefits (also see Module 3). One can value this time and skill by compensating financially or with time. Some groups avoid the compensation model by rotating the responsibility. However, the reality is that some physicians may not be a great choice for this important task. Failure to compensate is likely to result in the old adage, “you get what you pay for.”

Compensation summary:

1. Decide the values and priorities of the practice.
2. Identify the targeted/desired behavior.
3. Do not hide goodwill or tenure into the compensation formula.
4. Do not create carve-outs or “sweet deals” unless it meets the strategic interest of the practice.
5. Create a compensation model that allows for growth, taking chances and building relationships.
6. Create a model that is transparent, with fairness and equity.
7. Err on the side of being gracious and generous; the price will be offset by a higher quality partner.

Part-time status
I have always been struck by how contentious this issue is. One explanation is that each of us is trying to figure out how changing someone else’s status from full time to reduced time will impact us individually. We are, naturally, trying to make sure that the reduction in work results in an appropriate reduction in compensation. And, each of us may be struggling with a bit of envy. Before addressing how to reduce the workload, we need to decide if there is an inherent value in permitting and facilitating it. If the group finds no value, then there will be no real effort to find fair and equitable reduction in compensation. Secondly, there needs to be a decoupling of the compensation model from the individual making the request. There should be an agreed-upon formula or methodology long before anyone proposes a solution. Also, precedents are critical in this area. Given the potential legal risks involving age discrimination and the Americans with Disabilities Act, this formula needs to be blinded to these variables.

Is there value in part-time status? What are the downsides? Reduced work status will complicate scheduling, reduce flexibility in trading call, and will potentially increase others’ workload. An unintended consequence is that it may also create a vehicle to keep someone whose clinical skills have eroded and who perhaps ought to retire. The added dollars accruing to the other partners as a result of reducing compensation to a partner going part-time may feel inadequate to justify the resulting added workload. However, there are multiple potential
benefits to the group. The senior physician who remains a valuable member of the group has experience and wisdom that would be sorely missed in his or her absence. This wisdom is institutional, political and medical. Quantifying the value of this experience variable is tough, even when recognizing that this wisdom can foster many intangible benefits. The senior physician has perspective. He or she is able to put the most recent crisis in the appropriate light and remove some of the anxiety and drama. The senior physician is often a leader, whether formally recognized or not. The senior physician is a mentor to the mid-career partner. Finally, there is a group ethic, part of the group’s culture, which guides how we treat each other. Each of us deserves the graceful exit we envision rather than an abrupt release. If we treat our seasoned partners poorly, how will our partners treat us when we’re ready to “cut back?”

Reduced compensation models, therefore, are complex and emotional. Straight line models showing a 25% reduction in compensation for a 25% work reduction may not accurately weigh all the variables. If the 25% work reduction is across the board, then this model approaches fairness. However, if there is any asymmetry in work reduction, then it becomes more complex and emotional. Perhaps the greatest sticking point is the senior physician wanting to reduce or eliminate call. Here is where the challenges begin. How do you value call? Is call the same value for the new shareholder with little children at home versus the mid-career physician with teenagers, the sole provider physician versus the dual-income family? I would propose call has a different value for each of us. How the group values call will need to be a compromise and needs to avoid being punitive (but still fairly quantified). If the penalty is too great, then you may have physicians continuing to take call despite a physical or mental impairment (assuming the impairment hasn’t resulted in an official disability). If the penalty is too small, then there could be a rush of individuals signing up for reduced call. In addition to a formula, a trial period may be helpful. How does it work for everyone? Does it feel fair enough? Since most practice environments are not static, a mechanism is required to revisit the compensation at logical time intervals. In addition, it’s important to define how long someone can maintain the reduced status. Finally, with reduced status, is there a reduction in voting rights? Be careful here. If voting rights are reduced, this could result in disengagement by the involved physician, producing an “employee” rather than the more desirable “owner” mentality.

Another challenge is, who qualifies for a workload reduction? At first blush, a reasonable assumption is one of the senior physicians. However, it could be a new partner with health issues, home obligations, pregnancy, child-raising issues, etc. Perhaps the senior physician wants this work reduction to be permanent, while the younger physician needs only a few years. Furthermore, we are at the cusp of a generational change. The new generation may find positions more attractive with a part-time status. This could prove to be a recruiting tool and a concrete and attractive display of group values.

Transparency remains a critical element, as with a readily available, group-sanctioned work reduction compensation formula. This transparency may allow physicians to do their own math. If they are contemplating a reduction, they can explore this issue privately before approaching the group. Having clear guidelines or formulas in place will allow such exploration.

Finally, the group needs to remain in charge. If the part-time physician wants to return to full time, but a new physician has been hired to replace the missing work load, then remaining part time may be the only available option. If the part-time physician wants to further reduce their work load but not at a level that would allow the hiring of a replacement physician, then a reasonable decision may be that the request is denied. If the trial period is a failure for one side or the other, then either the part-time status is revoked or a revised formula is created. If someone is gaming the system, then the system needs to be fixed. This part-time status has to be a win-win for the individual and the group, and not a drain on the esprit de corps.
Part-time status summary:

1. Recognize that this is a very emotional issue.
2. Recognize that it is in the group’s best long-term interest to have such a model.
3. Decide on the mechanism and formula before anyone ever proposes work reduction.
4. Find a compensation compromise that avoids being punitive or overly generous, and that can be consistently applied.
5. Create a trial period.
6. Keep the group in charge of part-time status; who, when and for how long.
7. Use part-time status as a marketing tool for potential recruits.
8. Revisit the compensation model every couple of years, especially if the particulars of the business day have evolved.
COMMENTS FROM THE AUTHORS AND EDITORS ON THE CASE STUDY
The case of Nephrology Care Associates (NCA) illustrates a number of interesting observations regarding strategic planning. The idea that a strategic plan is the operational manifestation of goals, which originate from a broader vision, provides a framework for examining the case in detail.

The most striking aspect of Part 1 is that the founding partners of NCA do not seem to have a vision guiding their business. Clearly, they are satisfied with their position, possibly due to the fact that they have a monopoly on their market. When competition emerges, they fail to appreciate that it is easy for a small, nimble actor to compete with any perceived weaknesses in their service delivery. Remember, NCA cannot compete on price or, likely, on their perceived quality of care. Even if Dr. Sermon trained at an inferior fellowship program, as the NCA doctors seem to feel, most of the patients and the referring physicians will likely not see this as a critical difference in the day-to-day management of the typical nephrology patient. Most of the “customers” of a nephrology practice—the referring physicians and patients—often only look for a nephrologist’s friendliness, timeliness, and thoroughness in follow-up care. Beyond some reasonable degree of competence, Dr. Sermon’s training program is largely irrelevant.

Also of note, their choices of alternatives in Part 1 are largely reactive. It is highly unlikely that attempts to bar Dr. Sermon from privileges at the hospital will work without direct evidence of negligence, fraud, criminal activity or some other violation of hospital by-laws. As long as Dr. Sermon’s training program meets minimum accreditation and he has no obvious professional flaws, he will get credentialed. Most important, however, is the lack of a plan by NCA to address their weaknesses prior to Dr. Sermon’s arrival. Note they do not wonder if their relationships with the referring physicians are solid, what aspects of these relationships could improve, or how to ensure that any new threat to their referral stream is met early and head-on. The same could be asked about their patient relationships. Do they have timely office appointments available, friendly staff, and enough offices to serve the patients close to their homes? Why are they not surveying their referring physicians, their patients, and analyzing where the bulk of their business comes from? Why did they instantly leap to wondering if they should hire a fourth physician now, possibly adding further upheaval to their nephrology market without considering what could be done with their current staffing resources? Would the addition of another provider protect their market share? Is the problem one of availability (too few physicians for the work being generated) or something else? Having a clearly articulated vision—with the stated goals of maintaining or increasing their current market share, a detailed analysis of their practice’s market, and finding ways to improve their quality of life through optimally aligned operational processes—would have more likely led them to the questions they should be asking, rather than the apparently disjointed set of responses they proposed.

Seven years have passed by the beginning of Part 2. Unfortunately, Drs. Jones and Strathmore seem not to have been influenced by formal business strategy information in that time frame. They continue to have internal struggles over compensation, and a lack of vision and goal-driven leadership. Most importantly, they do not have a sound strategy for getting them the quality of life they want while protecting the long-term success of their practice.

The issues raised at the strategic planning meeting continue to demonstrate a failure to appreciate the importance of focusing on service excellence. There is variability in their consult timeliness, and they perceive, without any stated data, that they are not protecting their referral streams from both inpatient and outpatient sources. It is not clear how they rank the importance of these two issues. Also of note, with two newer physicians in the practice, they have not articulated a mission, vision or a clear set of goals and strategy that unify the physicians as a group. Thus, there is evidence of personal goals trumping practice goals, resulting in internal strife. Lastly, Drs. Jones and Strathmore are still overly focused on the quality of training and care delivered by their competition, Westside Kidney Associates (WKA). Whatever the quality of care is, it is good enough for WKA to have undergone a rapid expansion. Thus, instead of mounting a defense of their practice and ensuring...
high quality service, the leaders of NCA are focused on seemingly irrelevant factors and are failing to articulate or carry out a strategy to combat their declining market share.

Part 3 further illuminates the ongoing issues for the physician-leaders of NCA. In response to (not anticipation of, mind you) the NCA affiliated provider purchasing the local dialysis provider, the two groups discuss merging. The most striking question, from a strategy standpoint, is why? Drs. Strathmore and Jones seem to be stumbling through the strategic issues they face. They do not have a sound vision of where they want to go with the practice. The table of pros and cons seems focused on administrative efficiency with not as much thought given to growth and service excellence. It is clear there are some significant philosophic chasms that will need to be bridged with Dr. Sermon and his group (WKA). Beyond the concrete issues of leadership, the table points out stark differences between the two groups with respect to stated mission and vision, the stated expectations between each group and its physician-members, and the strategic planning process. Most importantly, WKA has a strategic plan of increasing market share and, as evidenced by their competitive success thus far, has been able to translate that strategy into realization of their goals.

It would be interesting to ask a few more questions with regard to how the NCA-WKA merger would impact strategic planning. For instance, would the combined group be able to negotiate better rates with insurance providers, thereby allowing them to compete with other nephrologists outside their current catchment area on price—i.e., get more money per encounter? This could allow for a decreased volume and improved customer service with the goal of attracting patients from outside their typical catchment area. Aside from interventional services, what other resources could be developed to ensure that they maintain or grow market share and protect or enhance their profitability? For instance, could they afford professional recruiting to ensure a steady growth with excellent staff, better marketing to encourage increased volumes of chronic kidney disease referrals, or deliver better customer service with enterprise-level technologic resources? Would the combined group have financial resources to open and run dialysis centers in new markets?

In the end, the lack of vision and organization, of leadership and awareness of the meaning of and importance of strategy development, seems to have been one of the biggest problems for the doctors of NCA. Without goals, without a plan, and without a consistent evaluation of their market, the work and time Drs. Jones and Strathmore invested in building their business will likely not yield a return beyond the reimbursement for their encounters. Instead of building long-term value in a large practice that might more easily absorb the cost of a retiring partner or a part-time schedule, their market was divided up among smaller entities, and they are left with the choice between facing a merger with a group they think is inferior, or slowly withering as their market share contracts.
Appendix

Governance structures

In each module of “Managing your Nephrology Practice,” we have described what we believe to be the best practices for managing a nephrology practice. One additional area of focus for all practices should be the way in which decisions are made. Decision making in a practice is often dictated by its governance structure; therefore, it is important to ensure that the practice has chosen the most efficient governance model. Proper governance structures will bring focus, structure and order to the decision-making process and will enable execution of the desired practice strategy. While there is no “one-size-fits-all” approach, there are several governance models that have proved successful in nephrology practices. The following are examples of effective governance structures that can be applied to your practice:

Rule by All model

In a Rule by All governance model, every physician in the practice is involved in the decision-making process (Figure 1). Typically, physicians will hold impromptu meetings whenever a decision needs to be made and use a consensus voting method. In a Rule by All model, each physician feels that they have a say in the decisions that will impact them. However, this model can become inefficient, especially when the practice is large. Also, some physicians may not be knowledgeable or interested in the decision-making process and feel burdened by the responsibility. The Rule by All model is best utilized by smaller practices where each physician is eager to participate in the management process.

Description

• All physician partners participate in the decision-making process
• Practice meetings are held whenever decisions need to be made

Pros

• Physicians feel they can participate directly in the decision making that will impact them
• All physicians have the opportunity to learn from the practice management process

Cons

• Unless the practice is small, the Rule by All model can be inefficient
• Some physicians may not be knowledgeable or wish to spend time on practice management
• The use of a consensus model may stall business decisions

Keys to success

• The practice should segment administrative responsibilities among physicians based on skills and interests to minimize administrative burden
• Recruit physicians who share similar philosophies and a commitment to practice management

Managing Partner model

In the Managing Partner model, one physician is elected to make the majority management decisions on behalf of the practice (Figure 2). With the exception of several important practice issues, the other physicians have little say in the decision-making process (See Module 3). One benefit of this model is that it allows one physician to spend significant amounts of time on administrative duties, leaving the other physicians to focus on medicine.
Occasionally, however, the other physicians may not agree with the decisions being made and may become resentful of the managing partner. Also, this model can become inefficient if the other physicians in the practice do not share the same values and philosophies as the managing partner. The Managing Partner model is best utilized by small practices (<5 physicians) where all physicians have trust in the managing partner.

Description
- One physician is chosen to make all management decisions for the practice
- The managing partner position may or may not rotate to other physicians

Pros
- One physician spends a significant amount of time on non-clinical and administrative duties
- Other physicians are left to focus solely on clinical practice

Cons
- Other physicians in the practice may not agree with the managing partner’s decisions
- Other physicians may not trust the managing partner and become resentful

Keys to success
- The managing partner should be one of the most experienced physicians in the practice with strong management skills
- The managing partner should encourage the involvement of other physicians by empowering them to take part in business decisions
- Roles and responsibilities in the decision-making process are matched to the skills and interests of individual physicians

Board of Directors model

In a Board of Directors model, a select group of physician partners are chosen to govern the practice (Figure 3). These physicians may or may not be the most senior members, and they typically serve terms of one to three years. This model has many benefits, as it allows for the physicians not concerned with the governance process to focus solely on medicine. Also, a Board model allows for diverse input from a variety of physicians. However, this model may cause younger physicians to feel underrepresented if the board is made up of only senior members. Also, if the board is too large, the decision-making process can become inefficient and time consuming. The Board of Directors model is best utilized by larger practices where the physicians in the practice place a large amount of trust in the elected board members.

Description
- A select group of physicians are elected to govern for a definite or indefinite term
- The board may or may not be the most senior physicians, but the board typically changes every one to three years

Pros
- A board of directors allows input from a variety of physician perspectives
- Other physicians feel they have chosen representatives who make decisions on their behalf

Cons
- If only senior members are on the board, younger physicians may feel underrepresented
- If the board is large, coming to decisions can be time consuming and inefficient
Keys to success
- The board must focus on strategic decisions and not day-to-day operations
- The board should delegate basic business decisions to the non-physician CEO or practice manager
- The board must drive consensus on the right issues

**Board plus Executive Committee model**

The Board plus Executive Committee model is similar to a traditional Board model, however the execution of decisions is done by an executive committee (Figure 4). An executive committee is a subset of the board that is elected to oversee the decision making done by the board. This model is very effective, as it allows for broad representation and input from multiple physicians. Also, with an executive committee, the board does not need to meet as often. However, this model often leads to a bureaucratic decision-making process and the generation of large amounts of paperwork. Additionally, when the executive committee becomes too powerful, board members may feel resentful or underrepresented. The Board plus Executive Committee model is best utilized by larger practices where a subgroup of physicians is selected who wish to spend significant time on the governance process.

**Description**
- Similar to a traditional Board of Directors model, except that much of the decision making and work is carried out by an executive committee
- An executive committee is a subset of the board that is chosen by the board or all practice physicians
- The chairman of the board typically leads the executive committee

**Pros**
- Allows for broad representation and input from multiple sources and perspectives
- If the board rotates, it allows for multiple physicians to take an active role
- With an executive committee, the board does not need to meet as often

**Cons**
- Can become bureaucratic and generate paperwork
- When the executive committee is very powerful, board members may become resentful or feel underrepresented

**Keys to success**
- The executive committee oversees the CEO, who makes operating decisions and reviews all physicians
- There must be a review process in place to encourage continuous improvement and change the behavior of physicians
- Segmenting operational decisions allows physicians to focus time on the most critical strategic issues
- Use formalized processes to provide structure and order to meetings
- Use consensus rule for all sensitive decisions

It is important to note that while all of these governance models have been successfully applied in many practices, there is often no single, right model for a particular practice. It is essential to evaluate your practice’s needs based on size, values and management philosophies. Also, no governance structure will be successful without mutual trust and communication. Each physician in the practice should feel comfortable with the way the practice is being managed. If done correctly, a successful implementation of a governance structure will lead to efficient and positive decision making in your nephrology practice.
Figure 1: Rule by All model

Figure 2: Managing Partner model

GOVERNANCE MODEL

Partners / Shareholders

Strategic decisions

Operating decisions

Managing Partner

Strategic decisions

Operating decisions

Figure 3: Board of Directors model

Board of directors

Strategic decisions

Operating decisions

Figure 4: Board plus Executive model

Executive committee

Board of directors

Strategic decisions

Operating decisions
Glossary Of Terms

Compact – Explains the “give” and the “get” that an organization has of its members, and that members have of an organization. Historically, compacts were unwritten psychological agreements, which often led to a misunderstanding of expectations. Modern-day compacts are best done in written form to ensure a mutual understanding of requirements and expectations.

Culture – The rules of behavior that stem from an organization’s collective attitudes, values, thoughts and beliefs. A company’s culture dictates what members of the organization expect of others, and serves as a predictor of behavior.

Goals – Measurable and observable outcomes to be achieved by an organization within a predetermined time frame.

Governance – The establishment and monitoring of policies and procedures by the governing members of an organization. The primary goal of corporate governance is to ensure the prosperity and viability of an organization.

Management – The day-to-day organizing, planning, controlling and directing of an organization’s resources to achieve stated objectives. An organization’s management team carries out the policy as dictated by the firm’s governing body.

Mission – The general purpose or goal of an organization. Usually expressed in a mission statement, a mission guides the actions and thought processes of an organization.

Mission statement – Expresses the mission and the services an organization seeks to provide. A mission statement supports the need to develop an array of professions to service the mission.

Objectives – Desired outcomes that can be reasonably achieved within an expected time frame. An objective is broader in scope than a goal, and may be comprised of several different goals.

Strategy – An organization’s tactical approach to the future that considers the firm’s external (customers and competitors) and internal environments. A strategy also serves as a tool to align an organization’s operations, vision, mission, culture and values.

Valuation – The appraisal or estimation of an organization’s economic value. An organization’s value is usually based on its current assets and earnings outlook. Valuation is typically done by using a methodology called discounted cash flows, where the asset’s value is determined by expected future cash flows. Other valuation methodologies include relative value modeling and options pricing.

Values – An organization’s shared beliefs or ideals about what is desirable and what is not. Values are a major influence on the behavior of members of an organization, and they act as a foundation upon which an organization navigates through its mission.

Vision – Describes where an organization is headed. A vision illustrates the mission and describes where an organization expects to be at a certain point in the future.
References


Additional Resources

**Building Your Company’s Vision** – A resource outlining how organizations can deal with change by utilizing a vision. *(Building Your Company’s Vision. Cambridge, MA. Harvard Business Review 65-77, October 1996)*


**Competitive Strategy** – Written by Michael Porter, a leading authority on strategy and competition, this book is the quintessential resource for devising and implementing a corporate strategy. *(Porter, M.E. Competitive Strategy. New York, NY. Free Press. 1980)*

**Finance for Managers** – A guide for calculating and assessing the overall financial health of an organization. Covers a range of topics such as financial statements, calculating return on investments, and valuation. *(Finance for Managers. Cambridge, MA. Harvard Business Review, 2002)*

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**Who Moved My Cheese? An Amazing Way to Deal with Change in Your Work and in Your Life** – a short parable by the author of “The One Minute Manager” that illustrates that change happens, and how to be prepared for it. *(Johnson, Spencer, Who Moved My Cheese - An Amazing Way to Deal with Change in Your Work and in Your Life, New York, Putnam’s Sons, 1998)*
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William H. Cleveland is a clinical nephrologist on the medical staff of five Atlanta hospitals and is Medical Director for four Atlanta Davita dialysis centers. He is President of Southwest Atlanta Nephrology and Nephronet LLC, a nine-provider practice, and is Past President of the Emory University Midtown Hospital medical staff. From 1991 to 1996, Dr. Cleveland served as Co-Medical Director for the Atlanta Committee for the Olympic Games and was a member of the International Olympic Commission.

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STUART SENKFOR, MD

Stuart Senkfor has been with Denver Nephrology, a 37-provider practice, since completing his nephrology fellowship at the University of Colorado in 1993. He served as President of Denver Nephrology from 1998 to 2003, and has remained on the Executive Committee since 2003. Dr. Senkfor also served as President of the Colorado Society of Nephrology and was Chief of the Nephrology section at St. Joseph Hospital from 1998 to 2005. He has been the Co-Medical Director of the DaVita Littleton Dialysis Center and currently serves as Medical Director of the Davita Lonetree Dialysis Center. He has been recognized by his peers in 5280 magazine as one of the Top Doctors in Denver (Nephrology) on multiple occasions.

Dr. Senkfor grew up in Cleveland, OH, attended Ohio Wesleyan University, and received his medical school education at Case Western Reserve University School of Medicine in 1985. He then moved to Chicago for his internal medicine training and chief medical resident year at Northwestern University, and completed his fellowship training in nephrology at the University of Colorado Health Sciences Center in Denver from 1989-1993. He is currently pursuing his Certified Physician Executive Certificate through the American College of Physician Executives.
MICHAEL SHAPIRO, MD, MBA, FACP, CPE

Michael Shapiro is President and CEO of Denver Nephrology, a 37-provider practice. Educated at Temple University School of Medicine where he received his M.D., he also earned his Masters of Business Administration at the University of Massachusetts-Amherst’s Isenberg School of Management. Dr. Shapiro is certified as a Physician Executive by the Certifying Commission in Medical Management and the American College of Physician Executives, is Clinical Assistant Professor of Medicine at University of Colorado Medical School, serves on the NCAP (Nephrology Coverage Advocacy Program) of the Renal Physicians Association (RPA), and is a member of RPA's Business Development Committee. He is also the Colorado Society of Nephrology Representative to the Medicare Carrier Advisory Committee, and was recently appointed to the position of Group Medical Director for Team Galaxy at DaVita, also serving on DaVita's Physician Quality Council.

PAUL TURER, MD, MBA

Paul Turer is President and CEO of Mid-Atlantic Nephrology Associates, P.A. (MANA) in Baltimore, MD. He earned a Masters in Science from the University of Pennsylvania, majoring in Biomedical Engineering, before attending the University of Medicine and Dentistry-New Jersey Medical School. His internal medicine training included serving as the Chief Resident at Baltimore City Hospitals, and he completed his nephrology training at Downstate Medical Center in Brooklyn, NY. He joined a two-man nephrology practice in 1982 and has overseen the growth of his practice to its current 35 providers and two vascular access centers. Dr. Turer has extensive experience in dialysis facility development and management, along with practice acquisitions and mergers. He received an MBA from Johns Hopkins University in 2002. Dr Turer has been on the advisory boards of Amgen, Ortho and Baxter.

ADAM WEINSTEIN, MD

Adam Weinstein is a nephrologist in Easton, MD and serves the five upper counties of Maryland’s eastern shore. He completed medical school, an internal medicine residency, and a nephrology fellowship at the University of Maryland School of Medicine. Dr. Weinstein co-founded The Kidney Health Center of Maryland, PA upon completing fellowship in July 2006 and has helped guide the practice’s rapid growth to its current four providers.
ADDITIONAL CONTRIBUTORS

PETER C. DONALD

Peter Donald serves as Vice President of Nephrology Practice Solutions. He has been working with nephrology practices affiliated with DaVita for the last five years and provides the following types of consulting services:

- Regional growth strategies
- Business strategies
- Management and governance issues
- Compensation planning
- Practice operations assessments
- Practice business leadership seminars

From 1997 to 2003, prior to joining DaVita, Mr. Donald served as a consultant and director for several development-stage companies.

Mr. Donald was CEO of a regional dialysis company from 1995-1997. He also held various CEO and executive positions in hospitals and hospital systems from 1973 to 1995. Between 1990 and 1995, he was CEO of St. Anthony Hospitals in Denver, CO.

Mr. Donald received his Bachelor of Arts degree from UCLA, and his Master of Science in Public Health from the University of Missouri in Columbia.

ANDERS CHRISTOFFERSON

Anders Christofferson is a Special Projects Manager at DaVita. He works in Nephrology Practice Solutions, which provides strategic development services to physician groups nationwide. He has extensive knowledge in nephrology practice governance and management, operations and strategic planning. Mr. Christofferson received his Bachelor’s degree in Business Administration from The George Washington University in 2008 with a focus in Marketing and International Business. Prior to DaVita, he worked in the marketing department at National Geographic Television & Film, and was a financial analyst at MIOGA Ventures, LLC.

Mr. Christofferson currently serves on the Board of Directors of The Foundation for Second Chances and Free World U. He resides in Los Angeles, CA.
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