

WHY AND HOW YOU MUST PREPARE YOUR ANESTHESIA GROUP FOR THE FUTURE

Mark F. Weiss, JD

The Mark F. Weiss Law Firm, Dallas, TX, Los Angeles and Santa Barbara, CA

Ah. The future. What's it have in store for your anesthesia practice and what must you do to prepare your group for it? Some think that the future will be a continuation of the present, or, even worse, a return to an idealized past. They're both wrong.

But the present does hold *clues* as to what the future will bring, and based on them, I'll make some predictions about what the future bears, and why and how you must prepare your anesthesia group for it.

Sure, I might be wrong about the *specifics*, but I'm absolutely *not* wrong about the overall direction. I'll make some concrete recommendations. And I'll raise a host of questions for you to think about.

The reality is that questions are far more important than answers. Questions that you can later ask yourself, questions that lead to other questions unique to



yourself, to your own group and to your specific circumstances, to help you discover your own particular answers.

SETTING THE STAGE

In order to deal with the future, we have to start with a very small bit of history in order to set the stage, to show how

Continued on page 4

► INSIDE THIS ISSUE:

Why and How You Must Prepare Your Anesthesia Group for the Future . . .	1
Becoming a Cheetah and Other Survival Tactics	2
The Winning Strategy for Billing Invasive Monitoring	3
Anesthesia Group Meetings: Madness or Method—the Choice Is Yours . . .	11
What is the Right Compensation for Your Providers?	18
Lessons Learned: Five Tips for Buying or Selling a Practice	21
Event Calendar	24

Anesthesia Business Consultants is proud to be a

MACRA *MadeEasy*
CMS-APPROVED QCDR

Anesthesia
Quality Institute
PREFERRED VENDOR



BECOMING A CHEETAH AND OTHER SURVIVAL TACTICS

In her [blog](#), *A Penned Point*, early this year, Karen Sibert, MD, president of the California Society of Anesthesiologists, asked her fellow specialists to take some time during Physician Anesthesiologists Week to celebrate the specialty's accomplishments, but also to reflect on the state of the profession today, the anesthesiologist's place in the current environment of competition and seismic change, and what being an anesthesiologist might mean 20 or 30 years from now.

"Is your group or practice running pretty much as it did 20 years ago?" Dr. Sibert asked. "If so, then my guess is that you are in for a rude awakening sometime soon. One of two scenarios may be in play: either your leadership is running out the clock until retirement and in no mood to change, or your leadership hasn't yet been able to convince your group that it can no longer practice in the same expensive, antiquated model."

She went on to note that "if the specialty of anesthesiology needs to reinvent itself—redesign what we do and how we do it—it isn't too late if we start now. The exact solutions and details of implementation will vary by location and practice setting. But inaction, and futile attempts to defend the status quo, are the biggest threats."

Though his approach differs, Mark F. Weiss, JD, of The Mark F. Weiss Law Firm, echoes Dr. Sibert's call to action in his lead article for this issue of *Communique*. "You must question whether your group's (and your own) current level of success and future prospects can be improved," he writes in *Why and How You Must Prepare Your Anesthesia Group for the Future*, based on his presentation at the 2018 Advanced Institute for Anesthesia Practice Management (AIAPM). "Despite your own best intentions, perhaps it's your anesthesia

group's governance structure that's holding you back." Mr. Weiss offers a diagnostic tool called The Medical Group Governance Matrix™ to help groups identify their current governance structure, with the goal of moving toward the nimble, responsive structure he uses the avatar of the cheetah to symbolize.

Reaching that point involves the willingness to let go of the need to personally control almost all aspects of a group's financial affairs—a need that in some groups is so strong that it can sabotage the group's ability to function as a true business. The result is a club, and a club does not equal a business, writes Mr. Weiss.

Also in this issue:

Kelly Dennis, MBA, of Perfect Office Solutions, Inc., whose articles you've seen here before and who led several sessions at this year's AIAPM, returns with straightforward, practical guidance in her article, *The Winning Strategy for Billing Invasive Monitoring*. Ms. Dennis emphasizes the value of open communication between the coding and billing and clinical staff to ensure that questions are answered in a timely manner. "Delayed billing while waiting for either a response or additional documentation is better than not capturing payment for your service," she notes.

Will Latham, MBA, of Latham Consulting Group, offers a comprehensive guide to planning and conducting effective anesthesia group meetings, where most of a group's most meaningful discussions, debate and decision-making typically take place. In his article, *Anesthesia Group Meetings: Madness or Method—the Choice Is Yours*, Mr. Latham recommends designating a meeting manager whose job it is to keep group members on track.

ABC Vice President Jody Locke, MA, probes the intricacies of calculating pro-

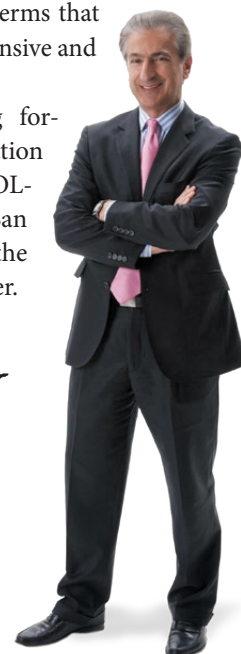
vider compensation and building a case for a new subsidy request in today's complex environment. What are reasonable benchmarks? How do you justify your request? He discusses the benefits—and limitations—of the main sources of national compensation data, and the role of geographic factors, payer mix, practice revenue potential, coverage and call requirements, income and lifestyle expectations, and a variety of other factors. "It is fundamentally about mastering the art of negotiation," he asserts. "Make your case, argue its merits, but be willing to accept and appreciate administration's goals and objectives."

Kathryn Hickner, Esq., of Kohrman, Jackson & Krantz LLP provides practical advice for buying or selling a physician practice in her timely article, *Lessons Learned: Five Tips for Buying or Selling a Practice*. Clearly define the purpose of the transaction, select transaction participants with care, develop a strong team that can be responsive and nimble during the negotiation process, rely on legal advisors and ensure terms that are clear, comprehensive and flexible.

We're looking forward with anticipation to ANESTHESIOLOGY® 2018 in San Francisco. Enjoy the rest of your summer.



Tony Mira
President and CEO





WHY AND HOW YOU MUST PREPARE YOUR ANESTHESIA GROUP FOR THE FUTURE

Continued from page 1



we got to where we are today. We'll do this on two tracks: one track is the anesthesia group track; the other is the hospital track, because anesthesiologists are, for the most part, still hospital-based physicians.

In connection with the anesthesia track, we need only go back as far as the 1970s. Then, almost every collection of anesthesiologists wasn't a group, because there weren't any, or perhaps there were just a handful of, actual *groups*. Instead, there were collections of individuals with medical staff privileges at a hospital and with clinical privileges in the hospital's anesthesia department.

Then along came the 1980s: Madonna, managed care, HMOs, IPAs. There was a sudden need for anesthesiologists to band together in order to contract with payers. Due to antitrust (price fixing) concerns, doing so required a financially integrated entity, that is, a true *group*. At the same time, the 1980s saw hospitals seeking commitments of coverage, and of anesthesiologists seeking exclusivity in return. That, too, led to the need for true business entities, that is, to groups. But the problem was, and we'll address it in detail later, that many groups were, and

continue to be, run more like clubs than as truly integrated businesses.

Now let's look at the hospital track. For this we have to go back much further in time, in fact, to before the American Revolution.

In the U.S., the first public hospital was formed in Philadelphia in 1751 by Dr. Thomas Bond and Benjamin Franklin. At that time, those who could afford medical care received it from physicians at home. The hospital was the method of providing substitute care to patients who either had no homes or were poor and could not otherwise afford medical care. This notion of caring for the public continued in the sense of the growth of religious chartered institutions. Again, those who could afford care did so privately.

As time progressed, physicians often advocated for the creation of publicly owned community hospitals; and physicians began to build clinics, i.e., hospitals, as an extension of their practices. In other words, hospitals were an adjunct to medical practice; medical practice was not an adjunct to hospitals. But over the following years, and decades, hospitals became larger and larger in order to meet

patients' needs. The high cost of the technology of the time made it more efficient to centralize equipment and the attendant care of patients as well as more efficient to provide observation and monitoring.

Yet there was still a clear line between the practice of medicine and related healthcare professions and the hospital itself, including the now almost quaint notion of an independent medical staff.

Then along came Madonna—the 1980's for hospitals. Large hospitals and chains developed employed staffs and related medical foundations, or more-or-less captive medical groups. But with the general collapse of the staff-based HMO model in the 1990s, many hospitals withdrew from the unprofitable business of attempting to control physicians.

Let's fast forward. Along came Obamacare, and the government chooses sides: what some may call *crony capitalism*. The American Hospital Association supports Obamacare. Obamacare cements in place prohibitions on physician-owned hospitals and favors the growth of non-physician owned hospitals with its incentives for "aligning" physicians, including accountable care organizations (ACOs) and other incentives to coordinate care, i.e., coordination via hospitals.

And so hospitals begin gobbling up physician practices. As hospitals gobbled up physician practices, hospitals began gobbling up each other as well. In 2013, there were approximately 98 hospital mergers. In 2014, about 95. In 2015, around 112. In 2016, approximately 102. And, in 2017, around 115 hospital merger transactions. Overall, since 2010, there has been a 44 percent increase in the pace of hospital mergers.

During all of those years, from 1980 to the early 2010's, the hospital business was humming along fine. And so, too,



was the traditional anesthesia group as a hospital-based practice.

THE UNFOLDING FUTURE

But, as they say in the financial world, past results don't predict future performance. Yet, many ignore that fact. They are comfortable with the current paradigm. They think that the party is going to continue because it's always continued. Yet, how does this work for turkeys? The farmers love them, or so they think. All the food and all the water they want! And then, the week before Thanksgiving—off come their heads. Thanksgiving is to the turkey as a set of disruptors is to the hospital. Let's look briefly at those disruptors. [For more detailed information on them, download a complimentary copy of my book, *The Impending Death of Hospitals*, at <https://advisorylawgroup.com/impendingcmnnq.html>.]

In essence, the disruptor is a perfect storm of technology, technique, price, value and the willingness to take entrepreneurial risk. For our purposes, that is, in the anesthesiology context, the disruptor is embodied in the shift of surgical care from the hospital setting to the outpatient setting. We can use the ambulatory surgery center (ASC) as the avatar for the shift, the placeholder for a variety of new forms of "non-hospitals," some of which look very much like the profitable parts of hospitals but not at all like the cost-sucking parts.

Technology allows a growing number of procedures to be performed on an outpatient basis. Those procedures can be performed in an ASC at far lower prices. And, due both to their lower cost structure and the ability to provide a more patient-focused experience, ASCs provide greater value for patients (better experience plus lower copays), for payers (lower prices plus better outcomes) and for physician-owners (capturing the facility fee plus greater control over scheduling plus increased professional freedom).

The future is clear: any procedure that can be performed outside of a hospital will be performed outside of a hospital. You see this in other specialties, too: for example, Anthem announcing, and in some states already implementing, a policy that it won't pay for outpatient MRI and CT scans performed at hospitals when, according to the company's third-party review process, the patient (and Anthem) could have saved money by going to a freestanding imaging facility.

What do you know; we've made a circle back to Ben Franklin's time: hospitals will simply be for the poorest patients in addition to, now, those that are the sickest.

ASC GROWTH, HOSPITAL RETREAT

In the 1990s, there were approximately 1,000 ASCs in the U.S. But by 2012, there were approximately 5,260. At the close of last year, it's estimated that the number had increased to approximately 6,150.

Note that those figures are a count of *facilities* and ignore the fact that some ASCs have grown to have large numbers of ORs. In fact, in 2010, the number of cases performed in ASCs was equal to that performed in hospitals. It's now surpassed them.

How's this climate change impacting hospitals? Well, we have a shrinking number of hospitals. There were approximately 5,010 community hospitals in the country in 2008. By 2015, there were 4,862. That number has continued to go down, in large part because of the shift of care to the ASC setting.

For example, in June 2010, New York City's approximately 400-bed, 160-year-old St. Vincent Hospital closed its doors for the last time. In late 2017, a competing non-profit opened the modern variant of a replacement "hospital" right across the street: a six-OR ASC located in a building with a separate emergency department, an imaging facility, physician offices and other healthcare services.

Other than the freestanding emergency room, which, depending on state law may or may not be possible to license (or even wanted), there's nothing in the concept of the replacement facility that couldn't be created by you as a physician-led, physician-owned for-profit venture. In fact, it's exactly along the lines of what I've termed a Massive Outpatient Center™ (MOC): A combination of an ASC, a medical office building and one or more of a menu of complementary offerings.

For some, thinking becomes ossified along historic lines: "Hospitals build hospitals." "Physicians just practice medicine." "Physicians can't own hospitals." None of these are necessarily true. But, even if they were, opportunity is more malleable. What's functionally like a hospital need not be a hospital. If I were wrong about this, St. Vincent's would be celebrating its 168th anniversary. It's not. A 200-unit condo complex stands in its place.

And then, we have an actual shrinking hospital. According to a January 8, 2017 article by Evan Belanger of *The Decatur Daily*, Decatur Morgan Hospital began chopping off the top three floors of its five-story south tower. The hospital's CEO was quoted as saying that the hospital's haircut is part of its "right-sizing" efforts.

If you're amused by actual shrinking hospitals, consider the concept of a bedless hospital. That is exactly what Children's Hospital of Michigan Specialty Center-Detroit is: a licensed, Medicare-certified, bedless hospital. And it's not the only one.

In fairness, it's important to note that weakness in hospitals, their fragility, isn't completely due to ASCs and to other outpatient facilities, and to payers pushing all of the care that can be pushed out to those independent facilities. There are other factors as well. Unions. Bloated



WHY AND HOW YOU MUST PREPARE YOUR ANESTHESIA GROUP FOR THE FUTURE

Continued from page 5



administration costs. Better medicines. Mergers that increased costs and didn't achieve savings. Huge overhead of "aligned" physicians. Perverse incentives in which hospital administrators have an upside only (high salaries, bonuses, perks) but no downside: no "malpractice" liability for their financial errors. (Tenet's recently failed CEO, Trevor Fetter, walked away with a \$22.9 million severance package after losing almost \$400 million in the prior calendar quarter alone.)

PREPARE YOUR ANESTHESIA GROUP FOR THE FUTURE

Before we move forward, even if you think that I'm full of, well, turkey poop, and that there's little chance of your hospital closing, consider the asymmetry of risk. Let's say that you think there's a 95 percent chance of no change, that things will continue as is. Then, it's a continuation of the status quo. (.95 x same thing or little increase = realistically, the same situation as today.)

On the other hand, there's a five percent chance of your hospital closing. But the impact of that happening is not a

slight reduction, it could be a complete blow up. (.5 x blow up = blow up.) Harkening back to our turkey example, you're not simply a lonely turkey, you are out of work, your partners sue you, your business "blows up." You're no longer a turkey, you're lunch meat.

Let's be clear: I'm not recommending that you jettison your hospital relationships. I'm simply telling you that you take action to prepare for a different future.

Prepare Your Group on an External, Macro, Basis

You need to hedge within your hospital-side business bets. If you haven't already, you need to expand to multiple hospitals. If one shrinks or closes, you want to have other sources of business.

But beware of work only with a single system. It's not the same thing. In my experience dealing with them, system-wide agreements are not a panacea. In fact, they might be a curse. Being tossed out of a system all at once is just as bad as being tossed out of a single hospital if it's your only significant place of work.

You need to hedge against your hospital-side business bets. Begin devoting significant focus to the ASC market as well as other emerging outpatient opportunities.

Don't be limited to "service to facility" or "service to surgeon" mindsets. You can become active participants, either within your group, alone or in concert with surgeons, in the formation of ASCs, or even of what I call, in my ASC development work, creating an MOC™: an ASC + aftercare + medical office building + imaging center + etc.—a hospital without the hospital.

Incorporate what I refer to as "flex down" provisions in your exclusive contract provisions. Beware of set coverage obligations, such as covering 17 ORs from 7:00

to 3:00 and 10 ORs from 3:00 to 5:00, and so on. If the hospital shrinks (physically or just in terms of the number of cases), you must be able to flex down any promise of specific coverage. To appease the few surgeons who haven't taken their cases to ASCs, hospitals *will* promise them more "flat" 7:00 starts with nothing for you to do in the rooms after, say, 10:00.

The same strategy applies to system-wide agreements. Be able to cut facilities from a system-wide contract that has you subsidizing a failing facility that might take you down with it. Or at least build in provisions triggering new stipend discussions. You can't be financially locked in long term.

At the same time that you incorporate flex down provisions, *you have to incorporate what I call "flex up" provisions.* Here are a few:

You must be able to flex up stipend support in the event that coverage can't be flexed down and, even then, there's some point where you become like firefighters, just standing around on call. But for you, no cases means no income generated. Similarly, when more business flows outside of the hospital to ASCs, and what's left is low-pay cases, it must *trigger renegotiation of increased stipend support.* If the stipend is not sufficient, then *you must have the ability to walk away, to terminate.*

Having negotiated anesthesia exclusive contracts since the 1980s, I'm keenly aware of the pressure on stipend support. But the times are changing and I'm also keenly aware of plummeting anesthesiologist compensation in many, if not most, markets, and of group failures. You need to have a smart negotiating strategy, not help finding jobs as hospital employees. That is the worst of all worlds. If the hospital subsequently closes, you'll have no employer, no group and no financial support.

If the hospital owns an ASC, you must have the right to provide coverage at that ASC. That applies to future ASCs as well, and to any facility that the hospital owns or controls. On the other hand, if the hospital doesn't have a controlling interest in an ASC in which it has ownership, then the hospital must use its best efforts to get you that contract if you want it.

And you have to be able to provide services at other facilities without restriction. Anything preventing you from spreading your business to other facilities has to be a nonstarter.

Preparing Your Group on an Internal Team Basis

You can't have any salaried physicians or CRNAs whose contracts can't be cancelled on somewhat short notice.

You can't promise facility-specific work. You may not be able to deliver it.

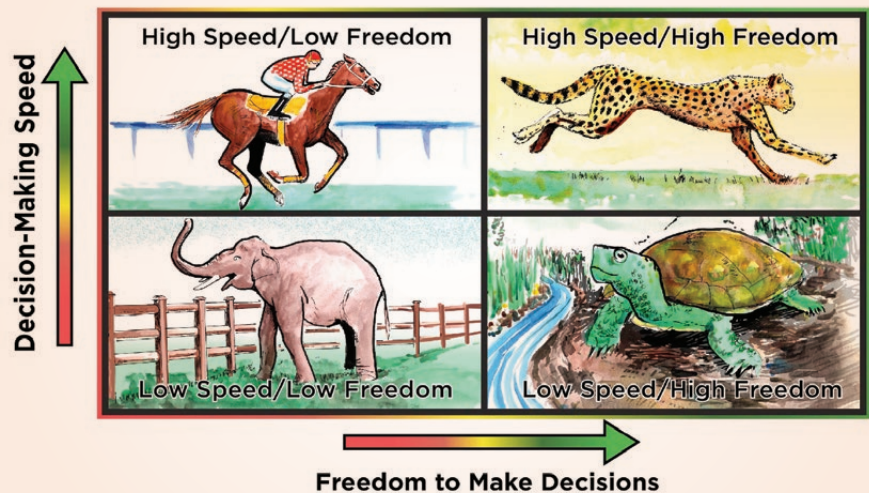
You have to understand LIFO and FIFO. LIFO and FIFO are acronyms from the world of wholesale and retail inventory, and for the way that a seller accounts for profit on sales. Are items accounted for as if the last one or the first one into inventory was the first one sold, that is, "Last In, First Out" (LIFO) or "First In, First Out" (FIFO)?

The same notion applies to members of your group when work slows down or a facility closes. Who is let go? How are they let go? Is it by seniority? Is it by skills needed? For example, what if the skills needed in a move from hospital-based to ASC-based practice don't match seniority? Your partnership agreements, employment agreements, and so on, all have to coordinate with your LIFO/FIFO strategy.

Even if you're not heavily focused now toward ASC practice, you have to hire for ASC skills and personality—especially personality. Candidates must have balanced social skills and the ability to work fast.

FIGURE 1

The Medical Group Governance Matrix™



Preparing Your Group on an Internal Governance Basis

In order to make any of the changes required, whether proactively or even reactively, your group must have a governance structure that allows leaders to lead and that allows decisions to be made quickly.

Too many anesthesia groups have painted themselves into a corner, unable to make decisions, because they allow far too many to participate in the decision-making process. If you can't come to decisions, *even the decision to not take action quickly*, then someone else—the hospital, an ASC, another group—is going to, in essence, make a decision for you, and it probably will be one you're not going to like.

I've worked with anesthesia groups with developed and effective abilities to make decisions. What was it that enabled these groups to make decisions quickly? There's a continuum of decision-making speed and freedom that's related to the group's governance structure.

It's important to note that I'm not assuming that your group isn't already successful or that you or your group is "damaged" in any way. *Rather, I'm stressing*

that you must question whether your group's (and your own) current level of success and future prospects can be improved. Despite your own best intentions, perhaps it's your anesthesia group's governance structure that's holding you back.

THE MEDICAL GROUP GOVERNANCE MATRIX™

Here's a simple four-quadrant diagnostic tool to help you find out. I call it The Medical Group Governance Matrix™ (see Figure 1).

Let's walk through the quadrants. Where does your group fall?

Zoo Elephant: Low Speed/Low Freedom (lower-left quadrant)

I use a zoo elephant for the quadrant's avatar because, although they are large, intelligent and powerful, and should be able to act decisively, they're trapped within their surroundings. They just don't have any room to run and to exhibit what could be their speed.

Unfortunately, this is the domain of too many anesthesia groups.

Zoo Elephant groups have one of three governance structures:

Continued on page 8

WHY AND HOW YOU MUST PREPARE YOUR ANESTHESIA GROUP FOR THE FUTURE

Continued from page 7

1. A very large management committee or board of directors; for example, a body with 10 or more members;
2. A fully participatory governance structure in which every group member votes on, and in some cases, can veto, any group decision or proposed action; or

Even though they have a formal, more streamlined governance system, the reality is that they fall back on a consensus system for actual decision-making. Consensus leads to compromise and waters down decisions.

3. These groups take too long to make decisions. The decisions they make are diluted by the need to obtain formal buy-in or consensus. Neither quick nor bold action is welcome.

Race Horse: *High Speed/Low Freedom (upper-left quadrant)*

I use a race horse for the quadrant's avatar because, although they are very fast, their ability to use that speed is constrained within the race track's barriers. There's no real freedom.

Race Horse groups have either a small management committee or board, or a solo leader. Conceptually, the leaders of a Race Horse group *could* make and implement quick decisions. However, their decisions are continually second-guessed. This can take the form of criticism or even active resistance. The leaders are blamed for their "poor decision-making" and quickly catch on that it's not in their personal best interest to stick their heads out. Maintaining the status quo receives the highest kudos.



Turtle: *Low Speed/High Freedom (lower-right quadrant)*

I use a turtle as the avatar for the lower right quadrant, representing low decision-making speed combined with high decision-making freedom. That's because they're free to roam. They just don't move very quickly.

Whether or not they are actually corporations, Turtle anesthesia groups tend to have a corporate-type structure. However, in practice, the officers' authority is largely micromanaged by the management committee or board of directors, which itself tends to be oversized. The officers are generally prohibited from taking *any* significant action, except as specifically authorized by the management committee or board.

From a freedom-to-lead perspective, measured by the reservation of actual authority at the management committee/board level, Turtle groups are champions. However, their often-large boards and the lack of effective delegation of power to the officers prevent quick decision-making.

Cheetah: *High Speed/High Freedom (upper-right quadrant)*

I use a cheetah as the avatar for the upper-right quadrant representing high decision-making speed with high decision-making freedom.

Cheetah groups have either very small management committees/boards or a fully empowered "strong leader." A Cheetah group's leaders are fully empowered to make decisions and they make decisions quickly.

The best way to describe this in everyday language is to say that even if the group's legal structure is a partnership, the governance structure is fully corporate: the leadership is either institutionalized via the governing documents or is elected on a periodic basis. The group doesn't have the right to overturn management decisions and the group's culture is not to interfere with leadership's decisions. Of course, if the structure includes periodic elections and the group loses faith in a leader, they are voted out of office.



These groups are very nimble. They can quickly respond to actions set in motion by third parties. They can quickly take action in regard to market cues. And they can quickly develop and implement proactive, market-making decisions.

BECOMING A CHEETAH

If your group isn't already a Cheetah, the object is to move your medical group's governance structure into the Cheetah quadrant—that is, if your group wants to best position itself in today's and tomorrow's market.

If your group is already a Cheetah, it still takes vigilance to remain one. That said, some groups view that goal—becoming and remaining a Cheetah—as having less value than other factors, such as their desire to maintain their club-like structure. As long as that's a conscious decision, made with an understanding of the trade-off, then it's perfectly valid—that is, as long as you don't expect both a high level of personal autonomy and a seriously competitive position for the group.

Where on the matrix is your group? Is that where you want it to be? Is that where it should be?

Let's turn to a thinking concept to help you get there.

AVOIDING GOVERNANCE MESSSES

I have a good friend who says, in the context of a physical skill, that prehistoric humans initially developed the strong, instinctual dominant-hand grip to be able to grab onto tree limbs and quickly climb in order to escape predators like saber-toothed cats. (I like my friend too much to tell him that saber-toothed cats could climb trees.)

The ensuing millennia have honed this instinct, so much so, that we instinctively grab tightly with our dominant hand even when the specific application calls for a much lighter touch. So, too,

goes the vice-like grip that causes many medical group members to hang on to their personal control, even when it actually cuts against their modern-day success.

They are so unable to let go of their instinctual need to *personally* control almost all aspects of their financial affairs that they dash their group's ability to function as a true business. The result is a club. (A club of a different sort would have helped with saber-toothed cats. A physicians' *club* does not equal a physicians' *business*.)

In order for a medical group to succeed, governance power must shift within the matrix from the lower evolved quadrants—from Race Horse, Zoo Elephant and Turtle—toward Cheetah. To do so, each member must let go of the individual control instinctually believed was required to save them from the metaphorical saber-toothed cat.

The reality is that one's future in a group isn't protected by preserving individual control. When the modern saber-toothed cat, the reality of business, is charging at you, it's absolutely no time for a vote. It's absolutely no time for "consensus-getting." It's absolutely no time for "any member may veto."

Deep down inside, we all have fears—some irrational, many completely rational. But prehistoric man survived by forming groups. That's what saved them from predators, saber-toothed and otherwise.

Here's where you can start:

Use The Medical Group Governance Matrix™ as a diagnostic tool to assess where your medical group currently resides on the continuum of management decision-making speed and freedom.

Ask yourself the tough questions:

1. How quickly does your group make management decisions?
2. Who's involved in making those decisions?
3. How quickly do your group's leaders implement decisions?
4. Is your group's governance structure fast and efficient or slow and plodding?
5. Is your group a Zoo Elephant, a Race Horse, a Turtle or a Cheetah? Is that where you should be?

In closing, let me assure you once again that I'm not assuming that your group isn't already successful or that you or your group are "damaged" in any way. But it's a given that the pace of change in the healthcare industry in general, and in anesthesiology in particular, is increasing, that business competition is intensifying, and that if your group doesn't keep pace, it won't simply remain where it is, it will be propelled backwards, perhaps into oblivion. ▲

Author's note: This article is based on my presentation of the same name at the 2018 Advanced Institute for Anesthesia Practice Management and draws from my book, The Medical Group Governance Matrix, a complimentary copy of which is available to Communiqué readers at <https://advisorylawgroup.com/matrixcmmmq.html>

Mark F. Weiss, JD, is an attorney who specializes in the business and legal issues affecting physicians and physician groups on a national basis. He served as a clinical assistant professor of anesthesiology at USC Keck School of Medicine and practices with The Mark F. Weiss Law Firm, a firm with offices in Dallas, Texas and Los Angeles and Santa Barbara, California, representing clients across the country. He can be reached by email at markweiss@advisorylawgroup.com.

