Seminar Leader

Mr. Latham is President of Latham Consulting Group, a consulting firm providing a variety of services to medical groups. For more than twenty years, Mr. Latham has assisted medical groups make decisions, resolve conflict and move forward. He focuses on the following areas:

- **Strategy and Planning**: Facilitation of the development of strategic, long-range plans to assist in direction-setting for the organization and improve physician relations.

- **Mergers, Alliances and Networks**: Facilitation of group merger planning, negotiation and operational implementation, group practice formation, and evaluation of integration opportunities.

- **Governance and Organizational Effectiveness**: Design and development of governance structure, physician/administrative team-building, and resolution of physician conflict.

- **Executive Search**: Retained search for medical group executives.

During his 35 year professional career, Mr. Latham has held responsible positions with a “big four” international certified public accounting firm and has provided consulting services to a broad range of professional and service-oriented companies. For over twenty-five years Mr. Latham has focused his efforts on serving the healthcare industry, primarily medical groups.

Mr. Latham is a graduate of Lenoir-Rhyne College with a Bachelor of Arts degree in Business with an emphasis in Accounting, and of the University of North Carolina at Charlotte with a Master of Business Administration (MBA) Degree. He is an Associate Member of the Medical Group Management Association and is a frequent speaker at national and regional conferences.

e-mail: wlatham@lathamconsulting.com
Seminar objectives

At the end of this workshop you will be able to:

- Identify the sources of dysfunctional behavior.
- Identify dysfunctional rules that increase conflict.
- Develop approaches to resolve conflict and reduce dysfunctional behaviors.
## Assessment: Team Effectiveness

**Instructions:** This assessment is designed to identify the attitudes and attributes of group and team effectiveness. Using the scale below, place a number to the right to indicate how often each statement is true. It is important that you answer each statement honestly and candidly without over-thinking your answers.

**Scale:**

3 = Usually  
2 = Sometimes  
1 = Rarely  
0 = Never

<table>
<thead>
<tr>
<th>Statement</th>
<th>Score</th>
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<tbody>
<tr>
<td>1. <em>Clear Purpose:</em> The vision, mission or goals for our group have been defined and is accepted by everyone.</td>
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<td>2. <em>Informality:</em> The climate tends to be informal, comfortable and relaxed. There are no obvious tensions or signs of boredom.</td>
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<td>3. <em>Participation:</em> There is a lot of discussion in our meetings, and everyone is encouraged to participate.</td>
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<td>4. <em>Listening:</em> The members use effective listening techniques, such as questioning, paraphrasing and summarizing to get ideas out.</td>
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<td>5. <em>Civilized Disagreement:</em> There is disagreement, but the group is comfortable with this and shows no sign of avoiding, smoothing over or suppressing conflict.</td>
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<td>6. <em>Decisions:</em> We have agreed on a specific process for making decisions as a group (seeking consensus, voting, etc.).</td>
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<tr>
<td>7. <em>Open Communication:</em> Group members feel free to express their feelings on issues. There are few hidden agendas. Issues are discussed at the meeting as opposed to “hallway discussions.”</td>
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<td>8. <em>Problem Physicians:</em> We effectively deal with problematic physician behavior.</td>
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<td>9. <em>Style Diversity:</em> The group has a broad spectrum of team-player types, including members who emphasize attention to tasks, goal setting, a focus on process, and questioning about how the team is functioning.</td>
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<tr>
<td>10. <em>Self-Assessment:</em> Periodically, the group stops to examine how well it is functioning and what may be interfering with effectiveness.</td>
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Total
ARE WE REALLY A TEAM?

A team is a relatively small number (3-20) of people that are interdependent, share common goals, and share rewards and responsibilities of achieving those goals.
WHY DO WE HAVE SO MUCH DYSFUNCTION?

- Group Dynamics
  - Different Personalities and Styles
  - Different Stages of Team Development
  - Different Approaches to Handling Conflict
- Physician Attitudes about Organizational Life
- Personal Characteristics of Physicians
- Low Value Placed on Team Effectiveness
GROUP DYNAMICS:
FOUR STAGES OF TEAM DEVELOPMENT

1. Forming
In the forming stage, team members test the waters to determine what type of behavior will be acceptable, what the nature of the team’s task is, and how the group will be used to get the work done. Forming is a period of dependency during which members look to the leader, to other team members, or to some existing rules for guidance. During the forming stage, there is a lack of clarity about the purpose of the group and about the expectations of the members. Members do not know each other, so they tend to be polite and obedient. Typically, they want to be told what to do, member status is based upon their outside roles, and interactions and discussions are superficial and tend to be directed to the formal leader.

2. Storming
Storming is characterized by conflict and hostility among team members and toward the leader as members resist the structure of the group. Similarly, there is some resistance to the team’s task -- although the nature of the resistance will vary with the type of task. The initial reluctance to express opinions in the forming stage is followed by a period of disagreement. Members feel free to disagree with each other and with the leader. Ideas are challenged, closely evaluated, and sometimes “shot down.” Members form alliances resulting in some group conflict, questions arise about both the task and process of the team, and there is some task avoidance as members enjoy the arguments. Teams that failed to experience storming never learned how to deal with differences. As a result, they develop a form of passive resistance whereby members simply go along with the leader or a small cadre of members even though they are not really in agreement.

3. Norming
The norming stage is characterized by acceptance of the team, a willingness to make it work, and the development of team norms. Norms are standards of behavior that the team develops for guiding members’ interactions and for dealing with the task. Information is freely shared and acted upon, and openness and trust emerge among team members. The team establishes guidelines for resolving conflict, making decisions, interpersonal communication, completing assignments, and the management of meetings. A competitive cohesion develops as the team feels superior to other teams, and there is laughing and joking that is associated with the informality of effective teams.

4. Performing
As interpersonal relationships become stabilized and as roles are clarified, the team moves into the fourth and final stage, performing. The group has a structure, purpose, and role and is ready to tackle the task. The emphasis here is on results, so positive problem solving and decision making take place. This is the payoff stage. The team is sailing along; they have learned how to be a team; there is agreement on goals, roles, and norms, and members are aligned toward producing results.

Self Assessment Questions:

1. What phase is your group currently experiencing?
2. What, if anything, do you think needs to be done to move your group to the next developmental phase?
GROUP DYNAMICS:
APPROACHES TO CONFLICT MANAGEMENT

The Conqueror Approach (I win – You lose)
- More focused on getting their goals than building a relationship
- Getting what they want is critical
- Hides or lies about facts and information
- Will use any tactic that will help them win
- Defeating the opponent is ultimate goal

The Avoider Approach (I lose – You lose)
- Fearful of conflict
- Lacks confidence in their ability to reach their goals
- Perceives conflict as inappropriate behavior
- Assumes conflict will disappear with time
- Will not engage in the discussion

The Accommodator Approach (I lose – You win)
- More focused on building the relationship than getting their goals
- Believes self-sacrifice is more important to maintain relationships
- Makes concessions quickly to show commitment to relationship
- Looks for middle ground

The Collaborator Approach (I win – You win)
- Focuses equally on their goals and building a relationship
- Consistently seeks the other person’s help in working out a solution
- Avoids “gotchas”
- Shares information and tells the other person their ideas
- Tries to understand the other person’s position

Self Assessment Questions:

1. Identify the different approaches of conflict management used in your group.
2. Which approach do you use?
3. How would you describe the group’s overall style in conflict management?
   a. Balanced and effective.
   b. Weighted towards one of the styles.
   c. A “train wreck.”
Physician Attitudes About Organizational Life

- Trained to be independent decision-makers.
- Desire for autonomy.
- All are bosses.
- General mistrust of organizations.
- Paranoia.
- Confusion over ownership and governance – I am the owner and I should have a say!
- Everyone has tenure!
- Finally, they don’t think about themselves as teams, and therefore see little if no need for finding ways to cooperate or team-build.

Personal Characteristics of Physicians

- Poor communicators.
- Relatively low level of “emotional intelligence.”
- Risk avoiders.
- Conflict avoiders.
HOW BAD IS IT?

GROUP DYSFUNCTION CASE STUDY

ABC Orthopaedics is a 15 physician orthopaedic surgery group providing services to patients in and around Gotham, Indiana. It’s 6:00 PM on a Wednesday evening, the time for the monthly group meeting. The only ones present are Dr. Jones, the president of the group, and the Administrator. If history is a guide, most everyone will roll in about 6:15 PM.

While waiting, Dr. Jones and the Administrator discuss several issues that have been raised since the last meeting:

• Dr. Peterson continues to cross Dr. Smith’s name off of the prescription slip for every prescription he writes.
• Dr. Jones was contacted by the hospital administrator in regards to one of the group’s physicians, Dr. Anderson, apparently stalking a nurse. This same physician has had several outbursts in the at the hospital (screaming at hospital staff) and many of the hospital staff will not work with him.

“How do we deal with these issues without it seeming like a ‘witch hunt’?” asks Dr. Jones.

As the other group members arrive and settle in, the group falls into its usual pattern. All of the physicians other than Drs. Jones, Peterson, Thomas and Able sit back and avoid being drawn into the conversation. Dr. Jones attempts to lead the meeting, trying to stick to the agenda, but Dr. Thomas is only interested in talking about the group’s compensation system tonight, and breaks in at every chance to raise the issue. One exchange sums it all up:

Dr. Jones: “The next issue on the agenda is looking at the idea of providing services at a new hospital Our Administrator has looked at several of the options, and…”

Dr. Thomas breaks in: “Why in the world would we want to work at another hospital? I’m too busy right now. I don’t want to have to do additional travel. I can tell you, if we don’t get some resolution on this compensation issue, I’m not going to travel to a new hospital. It’s all a waste of time. Why would we want…”

Dr. Jones: “Let’s talk about the pros and cons, and then we can look at some opt…”

Dr. Thomas breaks in again: “There are no pros, only cons. We need to get on to other, more important issues. Where do we stand in regards to the compensation system change I proposed? I think we should…”

Dr. Able tries to get into the discussion, but he is cut off by Dr. Thomas.

The group finally gets around to discussing the new service location, but does not reach a conclusion because they cannot achieve unanimity about the issue. They move on to other issues, with limited success.

By 9:30 PM, the physicians’ beepers start going off, and one by one they start leaving the room. Once the group dwindles to 6, a vicious argument breaks out between Drs. Peterson and Smith about call issues.
After the meeting, Drs. Stenson, Bush and Simpson stand in the parking lot and complain that the group does not ever seem to reach conclusions on any issue. “Did we make any important decisions? And did we decide to keep offering free coffee in the break room or not?” asks Dr. Stenson.

“And don’t you find it amazing,” says Dr. Bush, “that the behaviors of Drs. Peterson and Anderson weren’t addressed. What chance will we have for getting another service location if we can’t get along with hospital staff?”

Dr. Stenson notes, “Thank goodness these meetings only happen once a month!”

Discussion:

1. What examples of effective group/team behavior do you see in this case?
2. What examples of ineffective behavior do you see?
Resistance

They Resist:

- I’m not sick – you are!
- No “Kum Bah Yah” for me, thank you.
- It’s All Psychobabble.

But “Resistance is Futile”

- Coach, facilitate.
- Improve vs. Cure.
- “You get more accomplished when they don’t see you coming.”
CHARACTERISTICS OF EFFECTIVE TEAMS

Jot down some characteristics of effective teams you work with or have seen:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Phase 1 — Rules

- Ground Rules
- Decision-making
- Governance Structure and Systems
- Code of Conduct
From Me to We

GROUND RULES

Ask them, “What behaviors should be expected of each attendee?”

What you should hear from them (if they don’t say it, suggest it):

DECISION-MAKING

1. **How will the group make decisions?** Groups typically have four choices:

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<tr>
<th>Decision-making method</th>
<th>Comments</th>
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<tr>
<td>a. All decisions require unanimity.</td>
<td>A bad idea, typically leads to no decision.</td>
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<tr>
<td>b. Decisions require consensus.</td>
<td>The key positive is that it improves the chance of success in implementation. The negative is that it takes longer to reach “a deal” that all feel reasonably good about.</td>
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<tr>
<td>Consensus means working to a point where all don’t agree with the decision, but all will support it.</td>
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<tr>
<td>c. Decisions are made by a vote with majority ruling.</td>
<td>Good to use when you have limited time to make a decision, or when there are fundamental differences of opinion that are unlikely to be changed via discussion.</td>
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<tr>
<td>d. Seek consensus first, but if it cannot be reached, vote on the issue.</td>
<td>In our experience, this tends to be the best decision-making approach for medical groups. Someone must direct the group (often the group’s President) as to when to move from consensus-building to voting.</td>
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2. **What is expected of each physician once the group has made a decision?** Are they expected to support it? Does “support” mean “not sabotage” or does it mean “actively promote?” Are physicians expected to do what has been agreed to even if they did not vote for it?

3. **What are a physician’s options if they don’t like the decision?**
   a. ___________________________________________
   b. ___________________________________________
   c. ___________________________________________

If your group is having a hard time reaching decisions or making decisions “stick,” it’s probably because your group has not answered these three questions.
From Me to We

GOVERNANCE

Create a structure that achieves the following:

1. Set Mission and Vision and Assure Focus
2. Move Group Toward Strategic Goals
3. Oversight
4. Deal with Problem Physicians
5. Evaluate Management
6. Evaluate Board Performance
7. Over-Communicate with Constituents
Deal with Problem Physicians

Unfortunately, most groups deal with problematic physician behavior at one time or another. It often falls to the Board to assure that such situations are dealt with appropriately.

Options:

- Better to **reward than punish**.
- The potential for **embarrassment** will move mountains.
- A periodic peer **evaluation** system will help.
- Dealing with Problematic Physician Behavior.
  - Informal processes (typically doesn’t work).
  - Establish a formal system.
- Confronting Problem Behavior - Focus on behavior, not personality:
  - Describe the specific situation that illustrates the behavior you are concerned about.
  - Explain why it concerns you and express your desire for change.
  - Seek out and listen to the individual’s reasons for this behavior.
  - Inform the individual how improved behavior will improve his/her relationship with the group.
  - Ask for the individual’s ideas and commitment to solving the problem.
  - Offer your encouragement and support.
  - Agree on an action plan and set a date to discuss it.
Code of Conduct

- A Code of Conduct indicates the standards of behavior expected of a member of the group. It sets out, in general terms, the standards and duties which it is reasonable to expect a professional to observe. It is intended to protect the profession, individual practitioners and the group’s “customers.”

- Groups create a Code of Conduct for the following reasons:
  - As a vehicle to communicate what the group finds important about physician behavior and conduct.
  - As a method to improve the chances that the group will continue to have the freedom to govern itself.
  - As a method to hold errant physicians in check without making them feel they are under personal attack.
  - To remove personalities and private opinions if it becomes necessary to intervene in a situation.

- Questions to ask in establishing a Code of Conduct:
  - What behaviors do we expect of each other? What is acceptable to us? What is inappropriate?
  - What are some of the “unwritten rules” that guide our behavior?
  - What are the rights and responsibilities of each physician?
  - How do these expected behaviors support the group’s mission/vision?
Example Charter for
Professional Practice Committee

MEMBERSHIP

Three physicians elected annually by the Board in July.

QUORUM AND ACTION

Quorum is two of the three physicians.

Action on a matter may be taken on a simple majority.

In the event that a member of this Committee instigates or is subject to action by this Committee, the other two Committee members should appoint a member of the Board to serve as interim Committee member for that issue only.

MEETINGS

This Committee meets monthly to consider issues brought to its attention.

RESPONSIBILITIES

This Committee exists to consider physician conflict, physician performance and quality assurance concerns for the practice. The Committee will either work to resolve issues on its own or bring matters to the attention of the Board for resolution.
Example Process for Dealing with Problematic Physician Behavior

1. If a "concerned physician" has a grievance with another physician (the "physician in question"), or is concerned about quality issues related to another physician, his first step is to discuss his concerns directly with the other physician.

2. If the matter is not satisfactorily resolved in step 1, the concerned physician should handwrite his concerns and present this information to a member of the Committee.

3. At the next scheduled meeting, the Committee will discuss the issue and take one or more of the following actions:
   a. Decide if the issue has merit for further action, and if not, communicate this information to the concerned physician.
   b. Establish any necessary data-gathering process to determine if the concern has merit and what further action should be taken.
   c. Meet with the concerned physician and physician in question, together or separately, to gather information or counsel the physician.

4. If the matter is not satisfactorily resolved in step 3, the Committee should develop a recommendation to the Board for further action to resolve the issue. Such recommendation could include discipline up to and including expulsion from the group.

The Board will consider such issues at its next regularly scheduled meeting.
Example
Disciplinary Enforcement Policy

1. The Professional Practice Committee Chairman is responsible for administering the Enforcement Policy. He will convene a meeting of the Professional Practice Committee when he feels that it is necessary to evaluate the action of members which violate written or oral policies and which threaten discipline, order or good reputation of the group.

2. By simple majority, the Professional Practice Committee will decide the merits of each case and the appropriate disciplinary action.

3. Complaints from any source will be considered on their merits.

4. The first step will always be the opportunity for the member to clarify the situation.

5. Offenses and corresponding disciplinary actions will fall into four categories depending on their seriousness (see Levels of Offenses on next page).

6. For a Level 3 infraction, the subject member may appeal the decision of the Professional Practice Committee consisting of all available members who wish to participate. The appeal will be upheld by a simple majority.

7. If indefinite suspension or termination is recommended by the Professional Practice Committee, a vote will be taken in accordance with the group’s by-laws.

8. After a case has been completed, the Professional Practice Committee may decide to disclose its findings by a method it deems appropriate.
### Example Disciplinary Enforcement Policy, continued

#### Levels of Offenses

<table>
<thead>
<tr>
<th>Level 0: “Misunderstanding”</th>
<th>Defined As</th>
<th>Disciplinary Action</th>
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<tbody>
<tr>
<td></td>
<td>Isolated, unintentional mistake, and based on faulty information, and a mistaken choice based on reasonable options.</td>
<td>Counseling by the Chairman of the Professional Practice Committee. Possible memo to personnel file.</td>
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<thead>
<tr>
<th>Level 1: “First” or “Minor Offense”</th>
<th>Defined As</th>
<th>Disciplinary Action</th>
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<tr>
<td>Willful violation of important written or oral policies which the offender knew or should have known, and not an egregious offense as defined below, and first such offense or set of offenses documented.</td>
<td>Counseling by the Chairman of the Professional Practice Committee. A written warning will be given to the offender and documented in his/her personnel file.</td>
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<tr>
<th>Level 2: “Second” Offense</th>
<th>Defined As</th>
<th>Disciplinary Action</th>
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<tr>
<td>Second violation of a policy for which the subject was previously disciplined, or willful violation of another important policy.</td>
<td>Counseling by the Chairman of the Professional Practice Committee and the other members of the committee. A fine of less than $1,000 will be levied. A suspension without pay of up to one week will be imposed. The suspension may take place during the offender’s vacation week in order to minimize disruption of services. The actions will be documented in the offender’s personnel file.</td>
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<tr>
<th>Level 3: “Egregious” or “Third” Offense</th>
<th>Defined As</th>
<th>Disciplinary Action</th>
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<tr>
<td>Third violation of important policies, or legal or ethical lapse of such magnitude that the group is placed in serious jeopardy. Examples include but are not limited to patient abandonment, billing for fictitious encounters, sexual harassment, discriminatory behavior, or substance abuse.</td>
<td>Counseling by the Chairman of the Professional Practice Committee and the other members of the committee. A fine of less than $5,000 will be levied. A suspension without pay of up to 30 days may be imposed. The suspension may take place during the offender’s vacation week in order to minimize disruption of services. Indefinite suspension or termination may be recommended for a vote at a Shareholder meeting. The actions will be documented in the offender’s personnel file.</td>
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Phase 2 – Shared Vision

- Mission/Vision
- Strategic Planning
- Opportunities to Meet Without Conflict
SET MISSION AND VISION AND ASSURE FOCUS

| Mission | A statement of the group’s purpose and reason for being, and what it hopes to become.  
|         | Origin of the word “Mission” – something we were sent to do. |
| Vision  | A description about where they are heading as a group.  
|         | Their preferred future. |

Importance:

- Elaborates group thinking and identifies gaps in agreement.
- Efficient resource utilization.
- Sets the stage for all other planning.
- Used as a guide when setting strategy and making decisions. “Is this taking us toward our vision?”
- Most important: it gives you something to hang your hat on when you ask a physician to decide on what is best for the group rather than the individual.
**Mission Statement**

A Mission Statement is a statement of the group’s purpose and reason for being.

Medical groups develop a Mission Statement to help them communicate with themselves (and sometimes others) why the practice exists and to set parameters for what the group hopes to accomplish.

A Mission Statement answers the following questions:

- Why do we exist as an organization?
  - Who does the group wish to serve (consider geographic area, types of patients, types of referring physicians, etc.)?
  - What “customer” needs does the group wish to satisfy? “Customers” may include patients, referring physicians and others.
  - What are the core values and requirements for being a member of the group?
  - What principles or policies guide the group?
- How will working together as a group help us compete?
- What’s in it for each of us? What physician and staff needs does the group wish to satisfy?

A Mission Statement is intended to provide motivation, general direction, an image, a tone and/or a philosophy for the group.

**Vision**

- What is your preferred future?
- What does the group intend to become?
- Looking out 5 to 10 years:
  - What services and specialties do you plan to offer?
  - What geographic region do you intend to serve?
  - How many locations are you likely to have?
  - How big will the group become? Will you grow to fill the service needs of the market, or will you set an upper end limit on the number of physicians in the group?
  - What type of relations will you have with others? Will we remain an independent group?
  - What benefits do you hope to provide for the owners and employees?
Strategic Planning

- Internal Analysis: Strengths and Weaknesses
- External Analysis: Opportunities and Threats
- Identify Key Strategic Issues
- Discuss Issues, Set Strategy, Make Decisions
- Develop Monitoring Process

Opportunities to Meet Without Conflict

- Journal Clubs
- Social Events
Phase 3 - Team-Building/Skills

- Build Trust
- Effectively Deal with Conflict
- Achieve Commitment
- Make People Accountable

Adapted from *The Five Dysfunctions of a Team* by Patrick Lencioni.
Building Trust

The members of the most effective teams trust one another on a fundamental, emotional level.

- **Trust** is all about **vulnerability**.
- Vulnerability-based trust is hard to achieve, but it is achievable.
- If you don’t have trust, get *Roberts Rules of Order*.

**How:**

**Step 1: Personal Histories Exercise**

- Three questions:
  - Where did you grow up?
  - How many kids were in your family?
  - What was the most difficult or important challenge of your childhood?
- Why do this? By revealing aspects of their personal lives, they increase their comfort level with discussion other issues.
Step 2: Behavioral Profiling

- Objective, reliable means for understanding one another.
  - These tools point out the positives and negatives of each “type,” allowing a low stress way for members to admit their weaknesses (and strengths) to each other.
- Also gives them a common language to describe one another.
  - With this common language, it is safer to give feedback. Doesn’t feel so accusatory.
- Many options:
  - Myers-Briggs Type Indicator
  - Desa
  - Insights
  - Personal Skills Inventory
- Administering:
  - Explain the theory behind the profiling tool.
  - Administer the test (or do it before).
  - Provide their results.
  - Provide details about the profiling tool, including descriptions of each type.
  - Ask each to reveal their type and read the description of their type.
  - Discuss if this “rings true” and the implications of this information.
Effectively Deal with Conflict

- Trust is needed to be able to deal with the fear of conflict.
- Conflict is always at least a little uncomfortable.
- People have a concern about “how do you avoid the conflict getting personal?”
  - My experience, most teams never get close to anything remotely resembling personal conflict.

How:

- Conflict Profiling: Use Myers-Briggs or other method to understand everyone’s viewpoints and comfort levels with conflict (they can differ radically).
- Conflict Ground Rules: Update Ground Rules to identify acceptable and unacceptable behaviors around discussion and debate. Show this at every meeting.

Achieve Commitment

- Mission/Vision
- Strategic Planning
MAKE PEOPLE ACCOUNTABLE

If people are not accountable, over time they will lose respect for each other. Unfortunately human beings often choose the path of slow, uncomfortable decline.

To be accountable in uncomfortable situations, physicians need a way to share feedback with each other when individuals are not living up to the performance standards of the group.

How:

Team Effectiveness Exercise

- This is an advanced topic. It should only be used for teams that have already built some trust.
- Have every member write down their answers about every member of the team, excluding themselves:
  - What is the single most important behavioral characteristic or quality demonstrated by this person that contributes to the strength of our team?
  - What is the single most important behavioral characteristic or quality demonstrated by this person that can sometimes derail the team?
- All share the positive with one person.
  - Best to start with the leader.
  - Ask for general feedback when all finished.
- All share the constructive feedback with the same person.
  - Do not respond to feedback.
  - Ask for general feedback when all finished.
TAKEING ACTION

1. Review all the material covered in the workshop. If you have any questions, contact Will Latham at 704.365.8889 or wlatham@lathamconsulting.com.

2. Identify 3 to 5 key dysfunctional behaviors and prioritize improvements to be made.

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<tr>
<th>Key Dysfunctional Behavior</th>
<th>Your Plan to Improve</th>
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3. If it’s “major broken,” get the physicians to first agree on:
   a. How the group will make decisions.
   b. What is expected of each physician once a decision has been made?
   c. What do we do if someone doesn’t meet the agreed upon expectations?

4. Meet and develop mission, vision and strategic plan.

5. Then, address the other desired changes on a step-by-step basis.
The Challenge

Never before have medical groups faced so many challenges: the onslaught of managed care, utilization review, increasing competition, mergers and acquisitions, pressure to integrate with hospitals, and more.

And while the winds of change continue to blow, medical groups are faced with internal challenges such as managing growth, making decisions in a timely fashion, developing long-range plans, improving operational efficiency, and optimizing reimbursement.

Latham Consulting Group

Latham Consulting Group was formed to provide needed consulting services to medical groups trying to cope with these rapid changes. Simply stated, our mission is to help medical groups reach their full potential.

Our firm includes a network of thoroughly experienced professional consultants whose goal is to help medical groups improve their performance. Each of these professionals provide specific functional capabilities to meet the needs of our clients.

As a result of our network, we believe that our clients receive the most cost effective, highest quality services available in the industry. Because our affiliates individually have many years experience in their area of expertise, we are also capable of providing seasoned business judgment in a wide variety of disciplines.

In serving you, our consultants will bring:

- A commitment to producing tangible results.
- A sensitivity and responsiveness to your particular needs and interests.
- Know-how and judgment in their field of concentration.
- Sound, analytical problem-solving skills.
- Creative thinking and fresh ideas.

Key Areas of Consulting Expertise

Strategy and Planning
- Strategic Planning Retreat Facilitation
- New Service Planning

Merger Support Services
- Pre-Merger Assessment
- Merger Negotiation Facilitation
- Operational Integration Support

Physician Compensation
- Physician Compensation/Income Distribution
- Physician Contract Negotiations

Governance
- Practice Governance
- Physician/Administrator Team-Building
- Physician Conflict Resolution

Executive search

Why Choose Latham Consulting Group?

We believe that to be innovative, a service company must focus its efforts. That’s why Latham Consulting Group focuses exclusively on healthcare organizations.

Our experienced consultants provide services which are focused, practical, and tailored to your specific needs. We have a track record of satisfied clients we will gladly share with you upon request.

We would like the opportunity to demonstrate how we can help your medical group reach its full potential. For more information, contact:

Mr. Will Latham
Latham Consulting Group
704/365-8889
wlatham@lathamconsulting.com