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Optimizing Urology Group Partnerships: Collaboration Strategies and Compensation Best Practices

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Abstract Market forces in health care have created substantial regulatory, legislative, and reimbursement changes that have had a significant impact on urology group practices. To maintain viability, many urology groups have merged into larger integrated entities. Although group operations vary considerably, the majority of groups have struggled with the development of a strong culture, effective decision-making, and consensus-building around shared resources, income, and expense. Creating a sustainable business model requires urology group leaders to allocate appropriate time and resources to address these issues in a proactive manner. This article outlines collaboration strategies for creating an effective culture, governance, and leadership, and provides practical suggestions for optimizing the performance of the urology group practice.

Keywords Urology · Group Partnerships · Collaboration strategies · Compensation best practices

Introduction

Legislative and regulatory changes to the U.S. health care system are having a profound effect on the management and financial performance of urology group practices. In response to these changes, many urologists have adopted consolidation strategies through the formation of larger entities. While many practitioners have concluded that "bigger is better," most evolved urology practices have struggled with issues of culture, leadership, and compensation. Conflicting visions and values, along with differences in leadership and management style, have posed unique problems. An unresolved issue facing the majority of urology groups is how to effectively allocate revenue and share in overhead expense. This article focuses on the key issues of culture, governance, and leadership, as well as shareholder compensation, and provides practical suggestions for optimizing the performance of the urology group practice.

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Building a Common Culture

Culture can be defined as a comprehensive or shared understanding of guidelines, principles, social mores, and communication styles, resulting in commonly held assumptions and views among leadership and staff [1–4]. Although culture is a critical "hinge" in building a successful group practice, it can prove difficult to create and challenging to measure. Consequentially, minimal study of culture and collaboration best practices has occurred in both health care and business [5–7].

Urology practices have adopted unique dynamics related to shared resources and staff, investments in infrastructure, and provision of ancillary services. This clamant need for shared resource allocation often conflicts with practice patterns of expense distribution. Although many successful group practices advocate a "group think" mentality and cooperative culture, there are often factors involved that run in contravention to this collaborative mandate.

Collaboration is a process by which people who view aspects of a problem differently can constructively explore their differences and search for solutions that go beyond their

own limited vision of what is possible [8]. For urology groups, the adoption of this mindset can prove challenging, as newly formed partnerships struggle to ameliorate communication among stakeholders while striving toward shared vision and mission initiatives.

In an article in the *Harvard Business Review* entitled "Building a Collaborative Enterprise", authors Paul Adler, Charles Heckscher, and Laurence Prusak list four key areas for developing a culture based on trust and teamwork: (1) a shared purpose, (2) an ethic of contribution, (3) the institution of independent processes, and 4) the creation of a collaborative infrastructure [9].

Although many urology groups were formed to foster a shared sense of purpose, these same groups have adopted a more "individualistic" model of compensation that can prove ineffective in promoting this attitude. As such, many have found it challenging throughout the genesis and evolution of the merger process to achieve the level of teamwork and efficiency gains that had been hoped for.

In another *Harvard Business Review* article, "The Strategy That Will Fix Health Care," authors Michael E. Porter and Thomas H. Lee state, "Physician engagement can no longer be about short-term maximization of fee-for-service revenue; it must further the long-term strategy of improving outcomes and lowering costs – increasing value for patients" [10]. Achieving this goal will be difficult for urology groups if they remain unable or unwilling to modify shareholder compensation programs to better align with the group's long-term vision and strategy.

One of the most important factors in developing a sustainable business model is an investment in the creation of a mutual identity with a shared mission, vision, and values. In the case of groups contemplating a merger, these discussions should take place prior to going to the time, trouble, and expense of completing the transaction. Unfortunately, this step is frequently overlooked by group leaders as they fixate on imminent legal, financial, and operational considerations.

In the case of existing groups, it is recommended that the board and leadership team commit to this process. Group leaders may lament that mutual identity discussions will prove unfruitful or time-prohibitive, as they may uncover strained relations between key stakeholders. Balancing concerns alongside critical conversations may require the assistance of a third-party facilitator skilled in group governance and collaboration measures.

Table 1 provides an example of a partner survey used to determine a baseline analysis of group culture. Groups should consider implementing a survey using online tools or other methods for appropriate distribution. Results can be easily tabulated and presented to partners as a valuable tool in identifying initial areas of opportunity to improve partner communication and group culture.

Table 1 Partner survey

Partner Survey	Rating Scale
Urology Group XYZ has developed a *shared vision*, mission, and values that are supported by its strategy and processes.	1 2 3 4 5
Physician and Board leadership are balanced and effective.	1 2 3 4 5
Strong, well-respected physician leadership is in place to drive mission-critical decision-making.	1 2 3 4 5
Transparency and accountability exist throughout the group and are exhibited in day-to-day operations.	1 2 3 4 5
There is a process to achieve economic and clinical goals through collaboration and integration.	1 2 3 4 5
Financial incentives are aligned with group values and drive the right behavior for group mission, vision, values.	1 2 3 4 5
Variation in group practice patterns, quality, and operational performance measures are minimal.	1 2 3 4 5
Partner excellence is rewarded appropriately by group leadership.	1 2 3 4 5
Incentives are aligned appropriately for quality, patient satisfaction, and citizenship.	1 2 3 4 5
There is a process in place to address rogue or isolated partners who do not 'fit' the partner excellence structure.	1 2 3 4 5
There is a process in place to drive collaborative planning and decision-making.	1 2 3 4 5
Communication across the group is fluid, honest, and open.	1 2 3 4 5
There is a culture of accountability for leadership, MDs, and staff.	1 2 3 4 5

Rating Scale: 1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

Developing a Strong Governance Structure and Leadership Team

Historically, urology groups have elected individual shareholders to participate on the company's board of directors. The board assumed responsibility for developing policy and managing the affairs of the company. Delegated authority would be granted to an elected president or managing partner to carry out the policies and plans of the practice. This model can remain advantageous until a group reaches 15 or more shareholders. As groups grow in size and scope, this structure may lose effectiveness and create more strife than streamlined decision-making. Many larger urology group practices have found it beneficial for the shareholders to elect a board that can assume responsibility for managing the company. While the number of board members may vary based on group size, most groups have a board with an odd number of directors between 7 and 11 to ensure appropriate decision-making and to overcome potential stalemate challenges.

Effective decision-making in a group practice setting starts with a clear and well-constructed governance model. In the case of a professional corporation, the board of directors establishes the "rules of the road" concerning delegated

authority and governance. The board elects the officers, who are responsible for carrying out the day-to-day management of the entity. Depending upon the size of the group, it is not uncommon for a board to appoint various operating committees for company policy and provisional oversight for key functional areas including finance and accounting, personnel management, facilities management, marketing, operations, IT, and payer contracting. In some cases, the board may also appoint an executive committee (a smaller subset of the board) to work with the senior management team in implementing company policy and business planning. The key is to establish communicative consistency across the organization so that all stakeholders feel connected to the direction and decisions of the governing body. Figure 1 provides an example of a governance structure for a large urology group (20 or more MDs).

Analysis of successful large urology group practices reveals that a strong group president or managing partner is essential. Frequently, this position is assumed by one of the partners in the practice, but it is not always a full-time role. In other cases, the group will recruit a full-time individual either from within or outside the practice. Regardless of the nature of the position, it is recommended the board take the time to develop a job description that clearly outlines the individual's responsibilities and scope of authority. A sample job description is provided in Table 2. Additionally, a compensation plan for the president or managing partner should be formulated in alignment with the group's overall goals and values, which should take into account the amount of time and scope of responsibility assumed by the partner. In addition, the plan should be tracked precisely, rather than estimated, to avoid the potential for inaccuracy.

Table 3 provides an example of the delineation of responsibilities between the board and president.

Many large groups have evolved toward a more formal senior management structure through the adoption of traditional "C-suite" roles, including chief executive officer, chief operating officer, and in some cases, a chief financial officer. These decisions are mandated by the size, scope, service lines, and number of partners, as well as the overall complexity of the organization.

Key success factors in effective group governance include, but are not limited to:

1. Governing documents with clear lines of authority and decision-making criteria.
2. Effective delegation from the board to several functional operating committees, each with its own charter and guiding principles.
3. Accountability from each operating committee to the board for regular communications, including status reports on key committee initiatives.

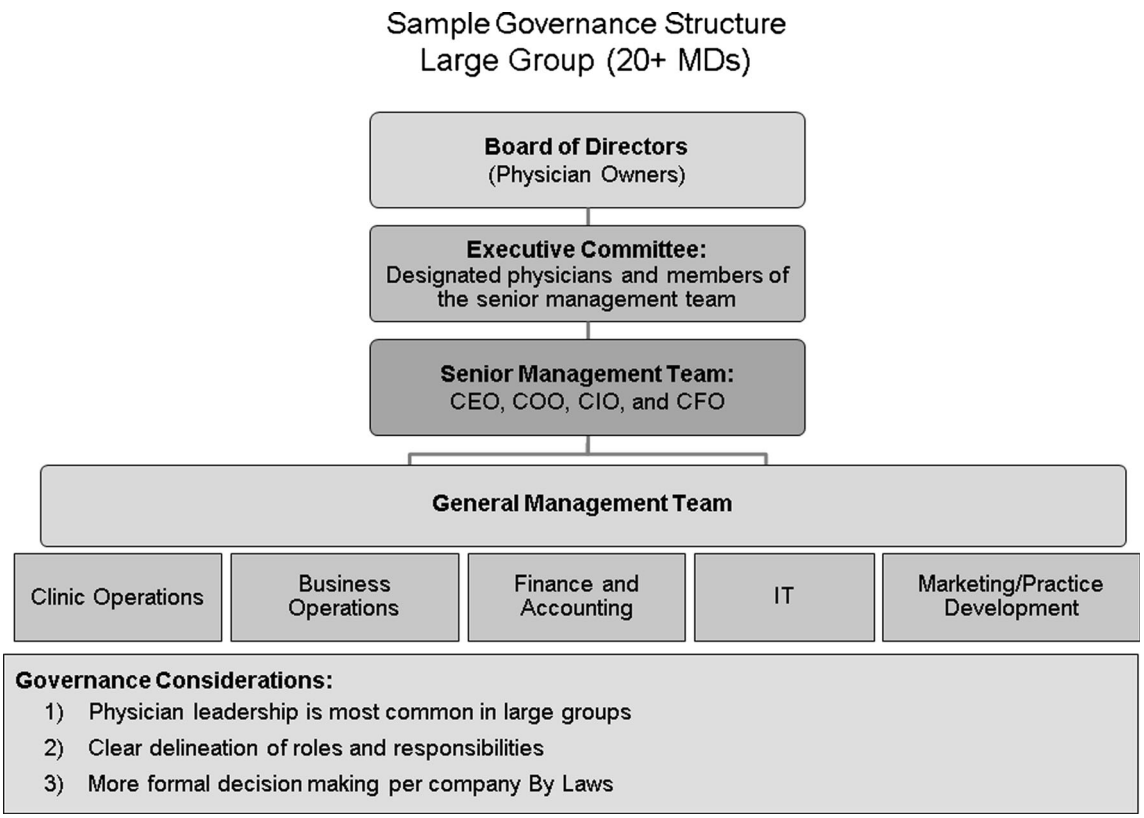

Fig. 1 Sample governance structure

Table 2 Job Description: President

Position Summary:

The President is appointed by the Board of Directors (the "Board"), and represents the Board and provides leadership and direction to the Administrator and management team. In addition, the President will provide leadership in carrying out the strategic plan of the practice. Knowledge of the different aspects of the practice's finance and operations, including the roles and responsibilities of the practice employees, is an important part of this job.

Qualifications:

The President will exhibit the following qualifications:

- Represent, without prejudice, the best interests of the entire group.
- Act in a non-partisan fashion.
- Act as an arbitrator or mediator when the situations arise.
- Provide a long-term vision within the context of group decision-making.
- Provide leadership in all aspects of group governance.
- Maintain a calm demeanor and exhibit appropriate decorum with management, staff, and doctors.
- Have or develop a working knowledge of business and financial matters.
- Have a working knowledge of practice operations including clinic flow, staff job descriptions, third-party contracts, and medical practice software.
- Represent the best interests of the practice in the community.

Authority:

- The President will be elected by the Board for a three-year term. The Board will conduct an annual review to assess the overall performance of the President.
- A supermajority vote of the Board is required for removal from office.
- The President shall act in concert with the Board, but may act independently when convening a meeting of the Board of Directors is not feasible.
- When acting independently, the President will coordinate decision-making with appropriate members of the Board as deemed necessary. It is anticipated that there are/will be infrequent instances where immediate action and decision-making is appropriate. Should the President take such independent action without consulting the Board, the President shall report such action to the Board as soon as possible.
- The President will chair all Board meetings or appoint a designee in his/her absence.
- The President will have regular monthly Board meetings as well as other meetings as deemed necessary. In addition, the President will meet on a weekly basis with the Administrator to review practice operations and relevant financial matters. When available, the President will also participate in management team meetings.

Duties:

- Provide leadership to the Board in the development of professional policy, group strategy, goal planning, and prioritization of key initiatives.
- Work in concert with the Administrator and management team in managing third-party contracts, including research agreements, managed care contracts, major capital expenditures, and facility lease agreements.
- Participate fully in all aspects of provider recruiting and hiring, including needs assessment, interviewing, development of compensation packages, and negotiation of employment agreements.
- Mentor and support new associates to assist them in meeting their objectives, while also assisting in their professional growth and development.
- Work with the Board, management team, or task forces to promote, implement, and participate in professional and business opportunities.
- Seek consensus or make decisions on policy where there is none established.
- Work with the Administrator and Finance Director to develop an annual budget and to track and review monthly income and expenditures. A preliminary budget will be presented to the Board for approval no later than December 20 of each year.
- When necessary, provide input and support of the Administrator on staff management issues.
- Coordinate and communicate with outside advisors to the practice, as needed.
- Time Commitment: the duties of the President are expected to consume an average of 8 to 10hours per week.

Compensation: TBD

4. Board commitment in providing resources and support to develop the business skills and strengths of the leadership team.
5. A well-thought-out succession plan focused on developing a leadership "bench" that will ensure long-term stability in leadership and management of the practice.
6. Board commitment to a formal strategic planning process that will bring continued focus on the company's vision, mission, core values, strategies, and tactics.

As mentioned previously, having a strong visionary leader or leaders is one of the most important defining factors of successful urology group practices. Effective leaders should have the following qualities:

- Adhere to influential and authoritative but benevolent leadership principles.
- Motivate, inspire, and influence physicians and staff.
- Own conflict resolution management and work effectively toward successful outcomes with administrative personnel.
- Innovate toward strategies for creation of best practices and optimal group efforts.
- Focus on improving health care outcomes.
- Focus on providing opportunities for employee development while attaining financial and operational results.
- Develop leadership opportunities for other members of the team and find creative solutions to short- and long-term challenges.
- Develop confident, principled, and ethical ways to approach job responsibilities.
- Garner the respect of leadership, physicians, and staff.

Urology group leaders should enact a disciplined approach toward developing communication strategies across their entire organization. A comprehensive, interconnected process reinforces core competencies and builds forward momentum toward active and honest discussion.

Table 3 Board vs. MD President Responsibilities

Board vs. MD President Responsibilities

	Board	MD President
Governance	• Ensures proper maintenance of legal and compliance requirements.	• Implements policy as set forth by the Board. • Is accountable to the Board.
Financial Management	• Approves the annual budget. • Monitors financial performance for adherence to annual budget and strategic plan.	• Develops the annual budget in consultation with the Board. • Establishes and presents regular financial reports and updates for the Board.
Planning	• Establishes direction for the strategic planning process. • Approves long-term strategic plan and annual business plan.	• Responsible for drafting of plans for submission to the Board. • Responsible for implementation of the strategic plan and business plan.
Human Resources	• Establishes company policy concerning compensation and benefits. • Responsible for legal compliance and compliance with state and federal regulations • Participates in the recruitment, selection, and development of Board members as well as management positions that report to the Board or senior leadership team.	• Works with the management team to implement company policy. • Provides direction and oversight concerning recruitment, development, and termination issues. • Establishes and drafts personnel policies for Board review and approval.

Compensation Planning

An effective shareholder compensation plan should be based upon mutually agreed-upon values and should be aligned with the group's mission and vision. Compensation structure should incentivize partners toward a culture of collaborative engagement versus exclusivity mandated on individualized performance. Our research has shown that many urology groups struggle to find the "right" compensation model. In the case of newly consolidated groups, many leaders have afforded partners from pre-merger practices the ability to retain previous compensation plans within each division. Although this approach may be effective as an initial transition strategy, it is important for groups to move the partners to a more unified and consistent long-term model of remuneration.

As discussions evolve from fee-for-service to fee-for-value practices, with the inclusion of value-based payment or risk models such as shared savings, bundled payment, and capitation, urology group compensation plans should anticipate provider payment changes and adjust accordingly.

Innovative compensation models are based upon the physician's success in achieving quality, patient satisfaction, or citizenship standards. As value-based reimbursement becomes increasingly common, evolving models should allow for compensation ratio adjustments to metrics that the urology group prefers to emphasize. Better alignment of payment incentives, transparency of performance measures, cost data, initiatives to improve efficiency, and incentives to coordinate full continuum of care within the group should be addressed and revisited annually.

Discriminating urology partners are also adopting aspects of compensation that recognize the comprehensive success of the group in order to further optimize group performance. This may include cumulative bonuses (e.g., pay for performance scores or shared savings), shared distributions earned through participation in bundled payment models, or overall group profit-sharing. These distributions may be allocated based upon individual performance, equal distribution, or other methodologies that blend individual performance with rewards for being a team player. In alignment with partnership strategies, compensation structures are highly personal and require customization based on transparent communications, specific metrics, and a dedicated focus.

A well-constructed shareholder compensation plan, if properly designed, can be an effective management tool. Board decisions involving major capital investments – e.g., new offices or equipment and hiring of physicians and non-physician providers – are easier when economic incentives are aligned within the context of the plan.

The keys to success in designing a compensation structure include:

1. Aligning the plan with the group's vision and values.
2. Recognizing individual differences in production and resource consumption.
3. Promoting transparency and accountability, and as such, encouraging shareholders to continually strive for improvement in patient care and practice efficiency.
4. Sharing the risk and benefit of investments made in passive income sources such as an ambulatory surgical center and employed non-owner providers.
5. Avoiding designing a plan that is too complicated to administer or requires continuous tweaks to satisfy individual shareholder requests.

There are two primary compensation models most often seen in urology group practices. In the first, revenue from all sources is pooled, overhead is paid "off the top," and profits are shared among the owners. With this type of model, there is some variability among groups in terms of the way that net profits are shared. In most instances, some agreed-upon percentage of net income is shared equally, with the remainder allocated based upon the individual production of the shareholders. Production is normally measured based on net collections (gross receipts minus patient refunds). The work component of Medicare relative value units (RVUs) is traditionally used as a measure of productivity.

There are variations to the pooled concept, wherein some overhead items are "carved out" and allocated on an agreed-upon method. For example, capital items such as interest, depreciation, and principal payments on debt service are often allocated in proportion to ownership percentages. In addition, it is not unusual to see physician direct costs (e.g., injectable drugs or facility fees) charged directly to the consuming shareholder. In addition, other physician expenses such as retirement plan contributions, CME, insurance, dues, and subscriptions are allocated to the shareholder as part of his or her total compensation package. Table 4 provides an example of the pooled or income-sharing model.

The second common approach to compensation in urology group practices is more "individualistic," where revenue is allocated to individual shareholders, and overhead expenses are assigned based on an agreed-upon formula. There are several categories of overhead expense in these models, including direct overhead and shared and non-shared expenses. Direct expenses would include the items noted above, and relate directly to the production of revenue. Shared expenses include the general and administrative expenses associated with operating the practice.

Table 4 Incoming-sharing model

Group Practice Compensation Model

Income-Sharing Model with Net income Allocation 50 % Equal and 50 % on Production

	Doctor A	Doctor B	Doctor C	Doctor D	Doctor E	Total
Revenue						
Owner MD Collection	$752,410	$677,360	$670,190	$792,755	$599,250	$3,491,965
Associates MD Revenue						2, 603,328
Other Income						85,412
Less Refunds						(67,668)
Total Revenue						$6,113,037
Owner Production Percentage (1)	21.55 %	19.40 %	19.19 %	22.70 %	17.16 %	100.00 %
Overhead Expenses						
Expenses (2)						$2,920,867
Associates MD Salary						911,165
Total Overhead Expenses Allocation						$3,832,031
Net Income						$2,281,006
Income Distribution (2)						
Income Distribution - Equal (50 %)	$228,101	$228,101	$228,101	$228,101	$228,101	$1,140,503
Income Distribution - Production (50 %)	245,743	221,231	218,889	258,920	195,720	1,140,503
Total Income	$473,843	$449,332	$446,990	$487,020	$423,820	$2,281,006
Physician Direct Expenses						
Retirement Contribution	($45,000)	($45,000)	($45,000)	($45,000)	($45,000)	($225,000)
Health Insurance	(19,554)	(12,003)	(18,652)	(16,445)	(13,625)	(80,289)
CME	(5,850)	(4,200)	(5,050)	(6,879)	3,850	(25,829)
Other Direct Expenses	(2,633)	(2,510)	(2,088)	(2,965)	(2,200)	(12,396)
Total Physician Direct Expenses	($73,037)	($63,713)	($70,790)	($71,299)	($64,675)	($343,514)
Net Income Distribution	$400,806	$385,619	$376,200	$415,721	$359,145	$1,937,492

(1) The owner production percentage has been calculated by dividing the individual owner-MD collections by the total owner-MD collections.

(2) Expenses include the cost of supplies.

(3) Income is allocated to the owner-MDs as follows: 50 % allocated equally and 50 % allocated based on individual production percentage.

Non-shared overhead items include the physician direct expenses noted above, and are generally allocated by individual shareholder.

In most practices that utilize this model, an agreed-upon percentage of shared expenses is divided equally, and the remaining overhead is allocated on some production measure. Our research has shown many operational variations on this model. In some groups, painstaking detail is taken with the assignment of each line item of expense, whereas in other models, the partners have agreed to an equal share percentage, with the remaining revenue distributed on the basis of production. Table 5 provides an example of the "individualistic" or profit center model.

As has been stated, it is of critical importance that urology groups design compensation structures in accordance with the vision and values of the practice. There is no incorrect approach. Problems ensue, rather, when a designated plan is not in sync with the practice or where partner behavior is in contravention to what is right or best for the group.

Conclusions

Over the past decade, a number of regulatory, legislative, and reimbursement changes have had a profound and multifaceted impact on urology group practices. To ensure that they remain viable, many groups have merged into larger integrated group practices. These larger entities have struggled to develop a strong culture, make good business decisions, and build consensus on how best to share income and expense. Building a successful and sustainable business model requires that urology group leaders invest the time and resources necessary to address these issues in a proactive manner. Research suggests that urology groups that have demonstrated success have outstanding physician leaders who recognize the importance of creating a common culture built around a strong mission, vision, and set of values. In the future, all urology group leaders will need to be adept at communicating effectively with group stakeholders. Additionally, partners must understand the value of developing a compensation plan that effectively aligns the incentives of the group with achieving long-term objectives.

Table 5 Profit center model

Group Practice Compensation Model

Profit Center Model with Overhead Expenses Allocated 50 % Equal and 50 % on Production

	Doctor A	Doctor B	Doctor C	Doctor D	Doctor E	Total
Revenue (1)						
Owner MD Collections	$752,410	$677,360	$670,190	$792,755	$599,250	$3,491,965
Associates MD Revenue	520,666	520,666	520,666	520,666	520,666	2,603,328
Other Income	17,082	17,082	17,082	17,082	17,082	85,412
Less Refunds	(13,534)	(13,534)	(13,534)	(13,534)	(13,534)	(67,668)
Total Revenue	$1,276,624	$1,201,574	$1,194,404	$1,316,969	$1,123,464	$6,113,037
Owner Production Percentage (2)	21.55 %	19.40 %	19.19 %	22.70 %	17.16 %	100.00 %
Cost of Goods Sold	($65,000)	$0	$0	($105,000)	$0	($170,000)
Overhead Expenses (3)						
Expenses-Equal (50 %)	($366,203)	($366,203)	($366,203)	($366,203)	($366,203)	($1,831,016)
Expenses-Production (50 %)	(394,527)	(355,174)	(351,415)	(415,682)	(314,217)	(1,831,016)
Total Overhead Expenses Allocation	($760,730)	($721,378)	($717,618)	($781,885)	($680,421)	($3,662,032)
Total Owner Income	$450,894	$480,197	$476,786	$430,084	$443,044	$2,281,005
Physician Direct Expenses						
Retirement Contribution	($45,000)	($45,000)	($45,000)	($45,000)	($45,000)	($225,000)
Health Insurance	(19,554)	(12,003)	(18,652)	(16,455)	(13,625)	(80,289)
CME	(5,850)	(4,200)	(5,050)	(6,879)	(3,850)	(25,829)
Other Direct Expenses	(2,633)	(2,510)	(2,088)	(2,965)	(2,200)	(12,396)
Total Physician Direct Expenses	($73,037)	($63,713)	($70,790)	($71,299)	($64,675)	($343,514)
Net Income Distribution	$377,857	$416,484	$405,996	$358,785	$378,369	$1,937,491

(1) Owner-MD collection are allocated to the individual provider; all other revenue is allocated equally to the owners.

(2) The owner production percentage has been calculated by dividing the individual owner-MD collections by the total owner-MD collections.

(3) The overhead expense allocation includes associate MD salary of $911,165.

Compliance with Ethics Guidelines

Conflict of Interest Dana L. Jacoby, Bruce S. Maller, and Lisa R. Peltier each declare no potential conflict of interest.

Human and Animal Rights and Informed Consent This article does not contain any studies with human or animal subjects performed by any of the authors.

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