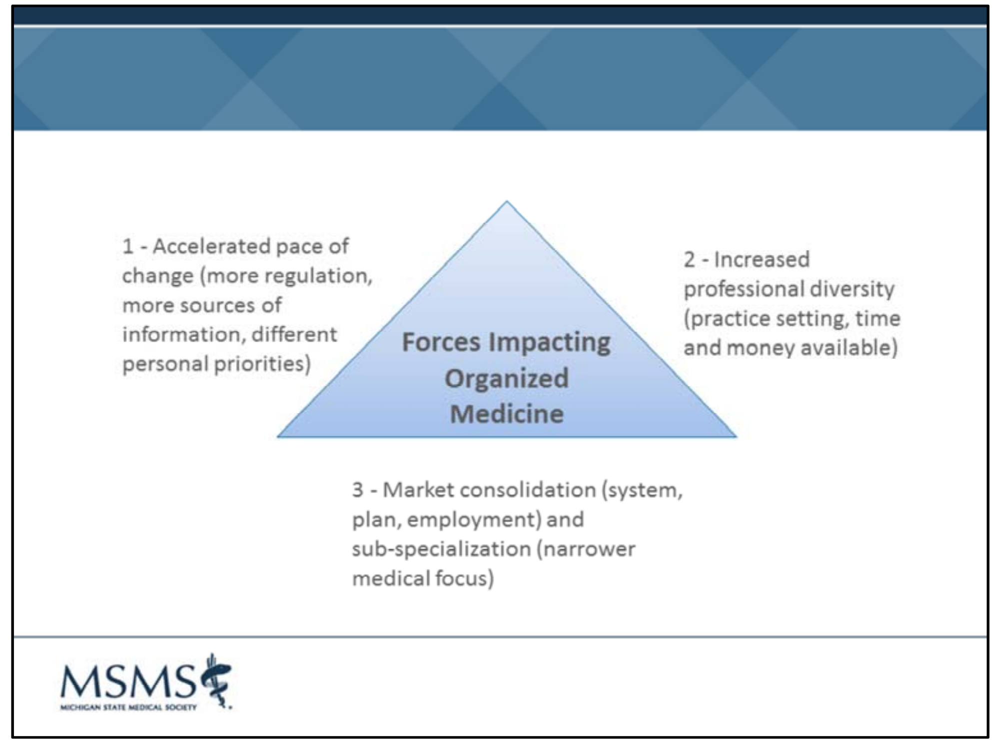
THE NEXT 150 YEARS…

Organizational Remodeling Discussion for the MSMS House of Delegates

MSMS marked a significant milestone, celebrating 150 years of serving physicians and their patients. That celebration also marked a time to address the changes in the profession and in the world, and to ensure that MSMS is structured in a way that will meet the needs of physicians well into the future.

First, we will review data that will summarize what happened in the last several decades, and then describe the current effort to take a comprehensive look at the organizational structure to prepare for input at the upcoming House of Delegates meeting.

First a look at the trends in medicine.



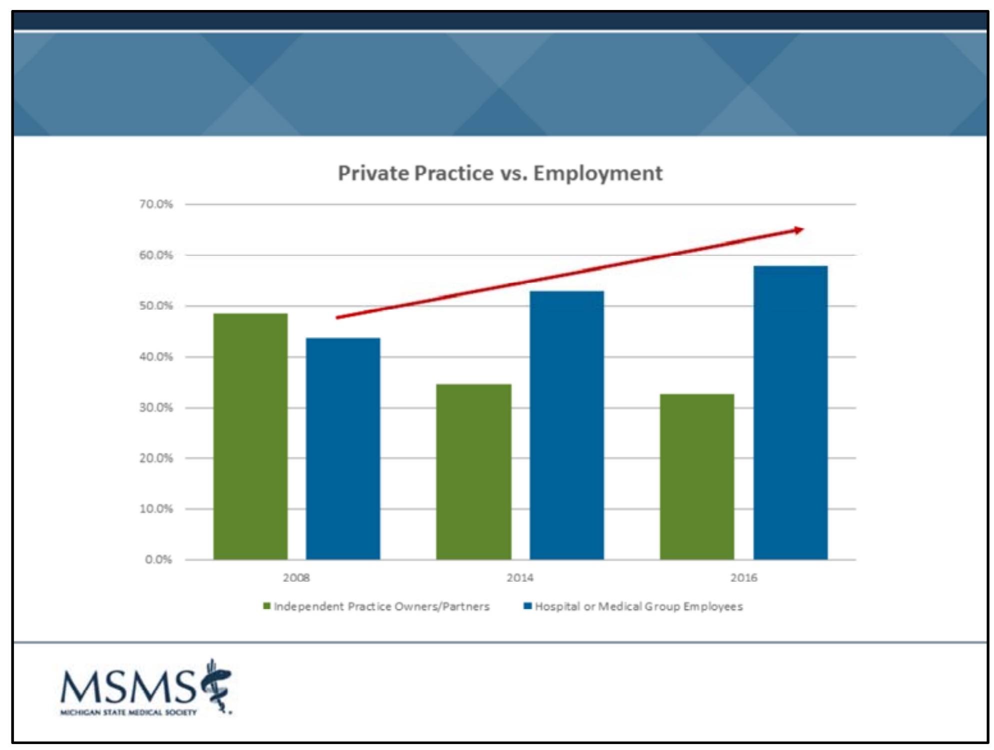
The pace of change has had a significant impact on the profession, and therefore on MSMS.

1 - Physicians face an increasing number of regulations from government, payers, and health systems. The challenge of keeping up with those, in addition to continuous advances in clinical care, taxes their time and attention. Associations no longer have a monopoly on information, which is now available from a wide variety of sources on demand. And new generations of physicians have different expectations about work-life balance, which impacts the time they might devote to a professional organization.

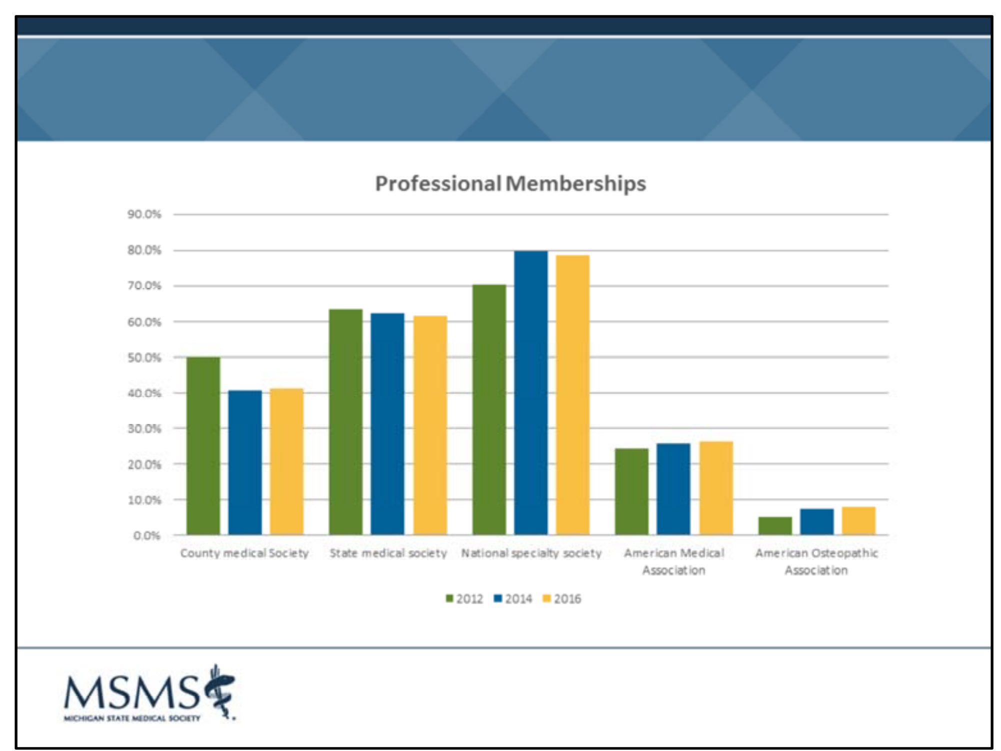
2 - Another significant force in medicine is the increased diversity in professional settings. Decades ago physicians were predominantly in small independent practices. They needed the types of services small businesses require and support in building their practices which associations offered. Today physicians are in many different practice POs or PHOs, large academic centers, hospital employment, single or multiple specialty group practices, and so on).

3 - In addition, the dual forces of market consolidation and sub-specialization in medicine mean their focus is much more specific, leading them to be more involved in other types of organizations.

These forces impact the value physicians perceive in organized medicine.



National data from the biennial Physician Foundation survey shows the increased trend toward physician employment. Although not Michigan specific, this trend is also significant here.



Also using biennial national data, this shows the trend away from county and state societies and toward specialty societies between 2012 and 2016.

Membership Competitors

Specialty Associations

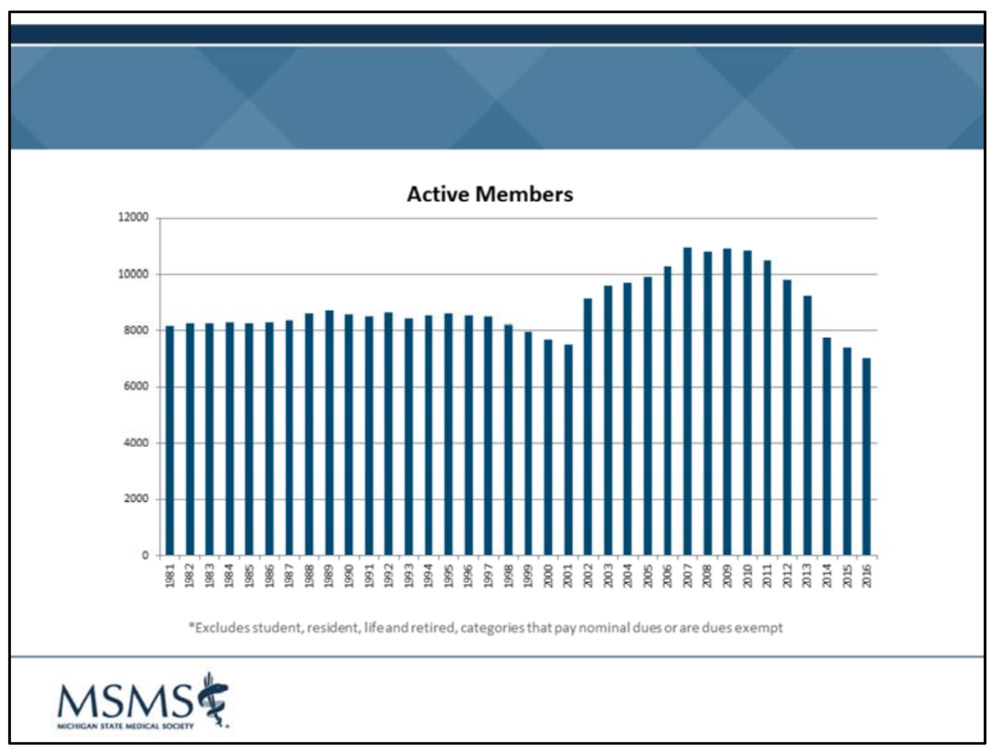
	Total Annual Dues	
Internal Medicine	$495	*Includes state and national*
Family Practice	$805+	*Includes local, state and national*
Anesthesiology	$1,050	*Includes state and national*
Obstetrics and Gynecology	$745	*Includes state and national*
Pediatrics	$150	
General Surgery	$604	
Diagnostic Radiology	$1,100	*Includes state and national*
Ophthalmology	$550	
Orthopedic Surgery	$400	
Emergency Medicine	$1,060	

MSMS
MICHIGAN STATE MEDICAL SOCIETY

The trend toward specialty societies means that MSMS is increasingly competing for dues dollars. MSMS dues range from $495 in counties that do not charge dues, to $880. This chart shows what Michigan physicians pay for the largest specialty societies.

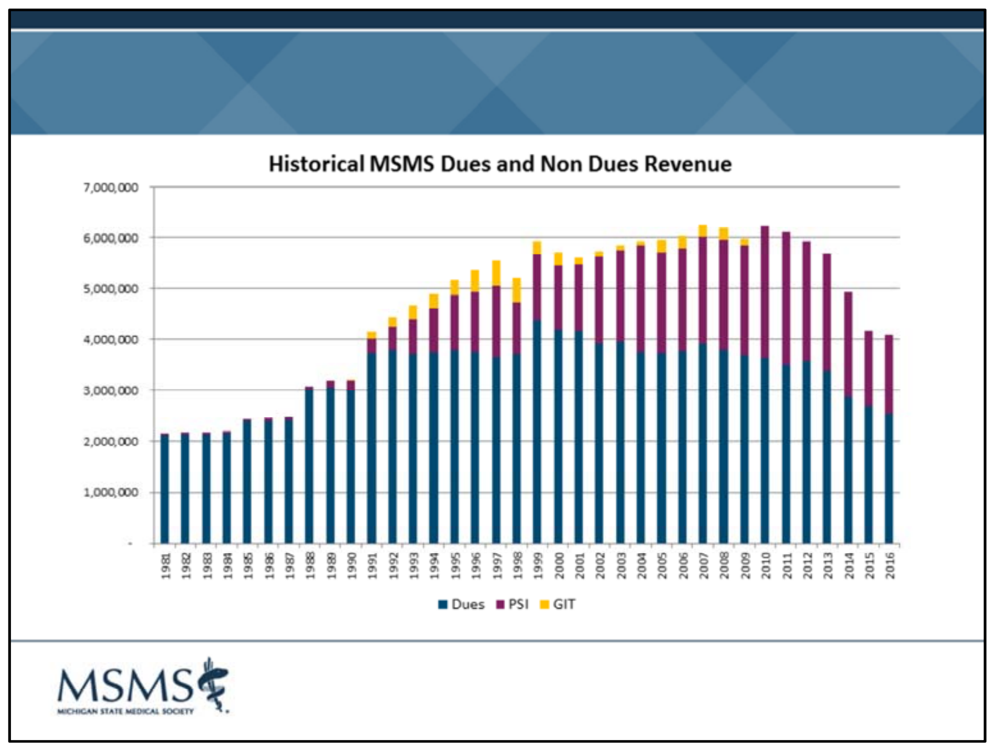
Once physicians have joined one or several specialties, paying an additional bill becomes less compelling, even though a broad umbrella organization like MSMS not only supports the agenda of specialty societies, but also works on issues they do not.

Whether physicians are employed and have a fixed fund for their various memberships and CME requirements, or are in private practice and struggling to balance increased overhead with constrained revenue, the price of joining MSMS has to be competitive with the perceived additional value.



This shows membership among active members for individual and group discounted practicing physicians. Not included are students, residents, and retired physicians—although important to MSMS, they do not provide significant dues revenue to fund the mission of the organization.

In the 2000s, the decline in membership was reversed with the addition of discounted group members, but the combined impact of individual member erosion and retiring Baby Boomers has re-established the negative trend.



MSMS activities are supported by dues revenue, shown in blue, and non dues revenue through Physician Services Inc., shown in red. The trend in the 2000s reveals that the discounted group membership increased the number of members, but was less significant in offsetting the decline in individual member dues revenue.

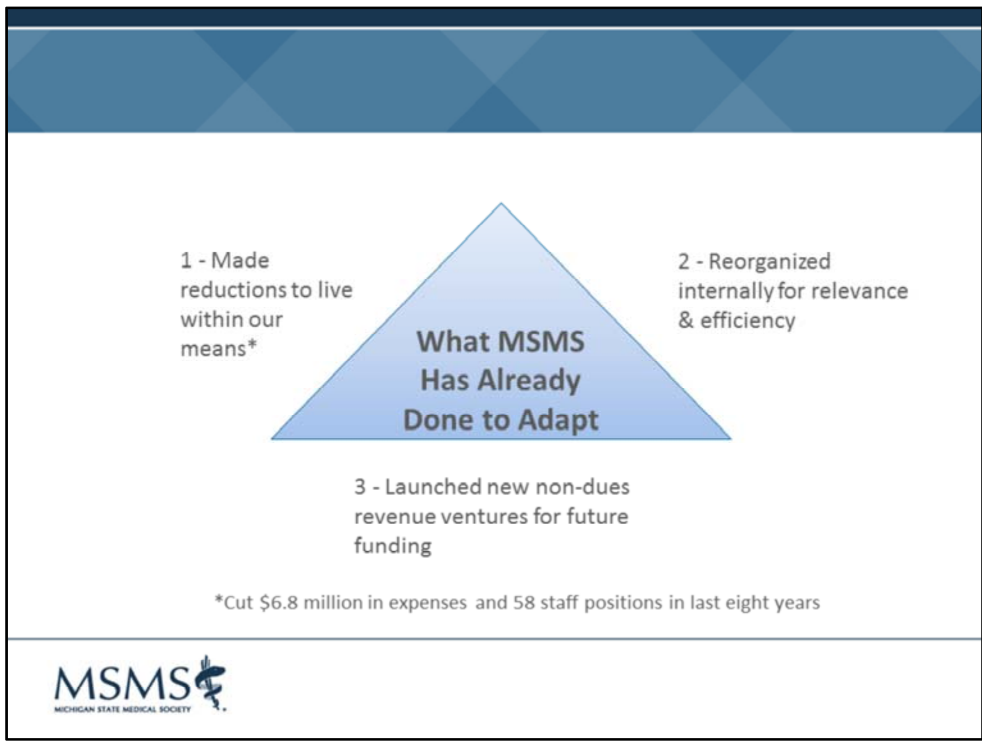
Non dues revenue, predominantly influenced by the group insurance market, is still significant revenue for MSMS, but the erosion of the group insurance market and the elimination of a specific product due to the ACA have reduced this revenue.

These trends have created challenges for our county partners as well. A number of counties have ceased to function over the last 10 years.

1 - Counties that do have paid staff and volunteer leadership struggle to do the same functions as they did in the past with less funds.

2 - They also have difficulty recruiting new or younger leaders to serve on the local board, serve as their representatives at the House of Delegates, or represent them on the MSMS Board of Directors.

3 - And with physicians integrating into larger groups that span beyond county borders, or taking employment within health systems, it is more difficult to articulate the value proposition of the local organization.



At the state level, MSMS has undertaken some major changes to adjust for the changing physician environment.

1 - The first was to find efficiencies and eliminate non-core functions without harming the essential mission.

2 - In the last 8 years, MSMS has reduced expenses by $6.8 million and eliminated 58 staff positions.

3 - The second is reorganizing to provide new services, such as the Executive Council of Physician Organizations.

4 - And on the revenue side, MSMS has launched several new business ventures that are intended to grow future revenue streams, such as WealthCare Advisors and Quantum Medical Concepts.

Next we will review what has led to the current organizational remodeling activity, and how it is different than past efforts.

Previous Efforts to Address Issues

- 1981: Task Force on MSMS Structure
- 1997: Governance Task Force
- 2002: Task Force on Regionalization of County Medical Societies
- 2003: Task Force on Regionalization of County Medical Societies in West Michigan
- 2006: Task Force on Federation Issues
- 2011: Governance Task Force

Only change made was to add student, resident and young physician seats to MSMS Board in 1997

This timeline shows that MSMS has been working to address structural issues for four decades. A variety of task forces have been created over the years, at the request of the House of Delegates. They were focused on specific problems, and they did not have the scope or tools available to define comprehensive strategies to address the underlying changes.

The one change that resulted from these activities was to add a student, resident and young physician seat to the MSMS board in 1997. Efforts to consolidate districts, reduce the size of the board, define qualifications for board members, or regionalize county societies were unsuccessful.

What Makes This Effort Different?

- Task Force for Membership and Sustainability
- Appointed by the MSMS Board of Directors after reviewing a 20-year trend of membership and revenue to address:
  1. Who do we serve? (Independent, employed, PO members, PO leaders, academic physicians?)
  2. How are we serving them? (Organizational principles and priorities and services offered)
  3. How do we sustain the organization? (Funding/dues models, relationships with other organizations, etc.)
  4. What is the optimal governance structure for the medical society going forward?

The current effort began with the appointment of the Task Force on Membership & Sustainability. The MSMS Board recognized that further cuts would impact core services, so the task force was appointed to examine four key questions:

1. Who do we serve?
2. How are we serving them?
3. How do we sustain the organization financially?
   And
4. What is the optimal governance structure going forward.

Engaged Outside Expertise

- Hired Tecker International
  - An international consulting practice focused on meeting the special needs of associations managing through change and helping clients solve complex problems and reach new goals.
  - **Glenn H. Tecker**, Chairman and Co-CEO of Tecker International (formerly Tecker Consultants) has more than 35 years of experience assisting associations and corporations in planning for change.
  - **Jim Meffert** is a Senior Consultant of Tecker International. Jim has more than 25 years of experience in associations and not-for-profit management, including working at the American Medical Association.

The focus is on determining what physicians will need in the future, and then organizing MSMS in ways that meet those needs. Because of the past challenges in getting beyond specific problems, MSMS engaged Tecker International, a firm that has extensive experience guiding organizations to develop their own ideal structure for the future.

Tecker Remodeling Process

- March 2016: Strategic Planning Session
- Summer 2016: Member & Nonmember Survey
- September 2016: Strategic Program Assessment
- October 2016: Remodeling Summit
- December 2016: Infrastructure Analysis
- January 2017: Consolidation of Models
- January 2017: MSMS Board of Directors meeting
- April 2017: TF on Membership & Sustainability

The experts from Tecker provide a methodology to define new approaches to old problems and to help organizations get past the "we've always done it this way" thinking, to create solutions that reflect how the world has changed, and will continue to change.

Their motto is, "Don't rush to no," so a significant amount of work preceded the special session of the House of Delegates.

Updated Mission Statement

The mission of the Michigan State Medical Society is to improve the lives of physicians so they may best care for the people they serve.

One of those steps, informed by member and nonmember surveys, led to this updated mission statement for the organization: “to improve the lives of physicians so they may best care for the people they serve.”

The statement is sufficiently broad to serve to guide the organization regardless of changes in the payment system, the regulations, or other things that evolve over time. It also reinforces that MSMS best serves patients and communities by supporting physicians in all aspects of their lives.

It is also intended to speak to younger generations of physicians who are redefining work/life balance and may have different professional expectations.

Proposed Goals

Physicians: MSMS physicians will be satisfied with successful practices in the most physician-friendly state with high levels of collaborative engagement in developing health care policy and driving innovation.

Patients: Michigan patients will be among the healthiest in the country as active members of affordable, timely, universally accessible, and evidence-based physician-led care teams.

MSMS: MSMS will have 100% membership of eligible physicians and medical students and will be a financially viable, respected, and influential organization whose members enjoy a high level of professional satisfaction.

The strategic planning discussion that led to the revised mission statement also created three broad goals:

1 - that our physicians would be satisfied, successful and work collaboratively to drive policy and innovation,

2 - that our patients would be healthy due to a well-functioning health care system and would participate in their health care in positive ways,

3 - and that MSMS would have broad engagement of physicians and medical students and have ample resources to serve them well.

Physician Engagement in the Process

- To date, more than 60 physicians, students and residents participated in various sessions
- Participants represented diverse practice settings, stages of career, specialties, and level of involvement with MSMS
- Collective input culminated in the October Remodeling Summit: developed five draft organizational models that address membership, governance, programs, and financial structure

These guiding ideals, and the draft models that will be described next, were crafted from the input of more than 60 physicians at all stages of career and in a variety of professional settings.

The remodeling summit held in October defined five proposed models. Because there was some repetition in those models, the Task Force consolidated down to three, and those three are being used to solicit feedback from House of Delegates members. That feedback will help to determine areas of consensus and parameters that will help the Task Force make further refinements in the next several months, resulting in a single proposal for consideration.

The three models that will be discussed at the House of Delegates will allow delegates and alternates to compare and contrast, to provide feedback on what they like and don't like about each, and to point out details that should be considered as we move forward.

There will be no formal voting, and it is not intended as an effort to pick one model over another.

Principles That Should Guide Us

- Data driven policy setting
- More mechanisms to get member feedback
- A nimble business model
- Price-competitive membership options
- Price consistency across the state
- Inclusiveness
- Consistent service delivery across the state
- Knowledge-based board leadership

All industries are facing the same challenges as MSMS, and the principles that should drive the discussion and our future work address what membership organizations need to be successful in the future:

- Data driven policy setting
- More mechanisms to get member feedback
- A nimble business model
- Price-competitive membership options
- Price consistency across the state
- Inclusiveness
- Consistent service delivery across the state

and

- Knowledge-based board leadership

Common Themes from TF Work

- Addition of integrated physicians (POs, PHOs, employed) to MSMS governance
- Smaller, more “nimble” board
- Focus the House of Delegates on policy, allowing the Board to focus on operations
- Modify the geographic structure of MSMS membership and governance
- Leverage relationship with the specialty societies

Across the five models that were proposed, there were consistent themes that developed:

- the important of integrated physicians in future MSMS governance,
- a smaller and more nimble board
- using the House of Delegates to set broad policies and the board to run the business side of the organization
- addressing the geographic structure of MSMS in some way
- and leveraging work that is done for the specialty societies that does not necessarily drive members or revenue to the degree that it should.

Various Levels of Change Proposed

- Make minor adjustments and hope the trends change
- Get innovative and risk unintended consequences
- Be realistic about the challenges and be willing to be innovative to protect the greater good

The three consolidated models have differing degrees of change in them:

1 - Make minor adjustments assuming the trends will change

2 - Get innovative and risk unintended consequences

3 - Be realistic about the challenges and be willing to be innovative to protect the greater good

Three Types for Discussion

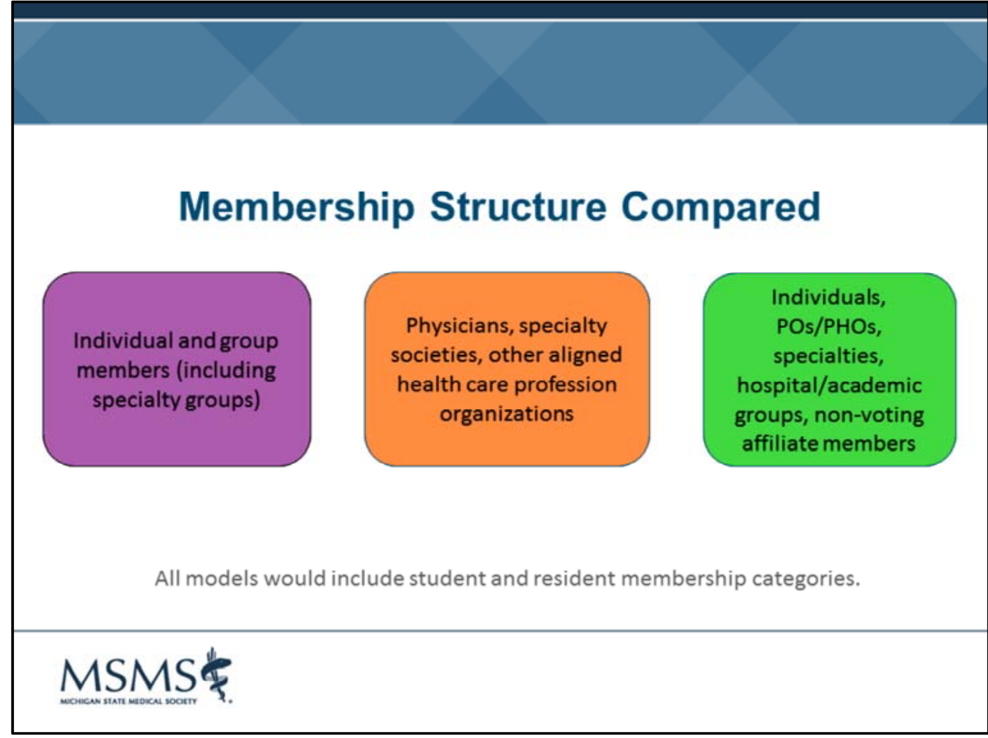
a. Adjustments Model: Very similar to current structure, some revision in board structure
b. Care Team Model: Meant to include team care representation beyond physicians to influence the direction of health care
c. Hybrid Model: Took features from all five models, focusing on innovation while preserving core of physician focus

Color coding will help you compare a few aspects of each model. They are conceptual models, and not all details of how they are constructed or would operate are defined at this point. That is intentional, to get input on the overall direction of each and gauge the level of change House members are willing to embrace. That information will allow the Task Force to build on consensus areas and formulate a more specific proposal.

1 - Model A, in purple, is the Adjustments Model, which makes a few changes to the current structure.

2 - Model B is the Care Team Model, intended to challenge the traditional boundaries of MSMS as a physician-only organization due to the changes in the health care delivery environment.

3 - Model C is the hybrid model, which takes elements from all five of the models proposed at the remodeling session. It preserves the core of MSMS as a physician-focused organization but proposes changes meant to increase engagement, modernize the leadership structure, and create additional efficiencies.



The first area of comparison is the membership structure of each.

1 – The Adjustments Model adds specialty groups as a membership category.
2 – The Care Team Model expands membership to include other aligned health care organizations, such as physician assistants, pharmacists, nurse practitioners. The premise of this model is that as the payment system moves to incentivize team-based care, it would be beneficial to have those other perspectives, and therefore development of policies, within MSMS. An example of an organization that has done this is the Society for Adolescent Health and Medicine, a multidisciplinary society devoted to advancing the health and well-being of adolescents.
3 – The Hybrid Model would expand the categories of physician membership to allow more options in pricing depending on the practice situation and the level of engagement. It would also allow a non-voting affiliate membership that provides access to MSMS resources—for example, law firms that would purchase access to MSMS's law library, or group managers who need MSMS resources but do not have a significant portion of their physicians that are members.

The House of Delegates is the membership venue for setting policy, and representation is allotted to county societies and specialty societies based on membership numbers, and to appointed section and specialty representatives.

1 – In the Adjustments Model, there is no significant change proposed in the House of Delegates process.

2 – Because the Care Team Model was more conceptual, it does not address the House of Delegates.

3 – The Hybrid Model would open the House to all members, in effect a membership assembly. This reflects both inclusiveness, and the fact that participating in meetings is much easier in modern times than it was historically. It also replaces the input that was traditionally gathered at well attended county or section meetings—with fewer counties having regular membership meetings, there is less information available from a broad range of perspectives. This model would also supplement member feedback in other ways—virtual discussions, online surveys, and perhaps regional meetings—while preserving the face to face interaction that currently happens at the House. The House might evolve from individual resolutions to a discussion of broad policy areas or

emerging trends that determine the organization's work.

All of the original models proposed in the remodeling session reflected that modern boards need to be smaller, more nimble, and reflective of specific perspectives and knowledge. The current board is 34 voting and two ex-officio members. The majority of voting members represent geographic areas, with the remainder being House-elected officers and the section representatives. In the past, the board has been as large as 45 members.

1 – The Adjustments Model sets the board size at 23 members. Twelve would be elected by districts, and the remainder would come from various practice setting perspectives or other constituency-based representatives.

2 – The Care Team Model would have an executive committee that is only composed of physicians. The board would include representatives from the aligned health care profession groups but would still have a physician majority. A series of advisory councils would allow input from a greater number of physician constituencies and each of the non-physician professional groups.

3 – The Hybrid Model board would be composed of 16 members—nine elected at large using pre-determined criteria to ensure a diversity of perspectives. Because the House is inclusive of all members in this model all members could vote electronically on a slate that meets the criteria. The remaining 7 members

of the board would be officer positions (president, speaker, etc).

To reiterate, these models are meant to evoke feedback and determine areas of consensus, allowing the development of a more specific proposal for consideration. The next steps in this process are the following:

Tools To Facilitate Discussion

- MSMS DocExchange community to encourage comments and questions
- Mailer to HOD members
- Presentations at live meetings
- Materials for district director briefings
- Special emails to HOD members
- FAQs
- Talk with your MSMS board district director
- www.msms.org/organizationalremodeling

MSMS's online community, DocExchange, has a specific forum for providing feedback on the information presented here and posting questions or additional thoughts. All physicians that have been identified as delegates or alternates have been invited to participate in this DocExchange community.

Leading up to the House, we will be encouraging physicians to review this material and other resources through special mailings, electronic notices, presentations at local meetings, and information available for district director briefings.

We also encourage you to talk with your district directors, and visit www.msms.org/organizationalremodeling for more information.

May 6, 2017: House of Delegates

- Draft models will be discussed in a special second meeting of the House Saturday afternoon from 2:00 to 4:00 p.m.
- The goal is not to choose a model but to get additional feedback that allow us to do further identify areas of consensus
- Address what are the advantages and disadvantages to each model

At the 2017 House of Delegates, there will be a special second meeting of the House from 2:00 to 4:00 p.m. on Saturday, May 6. Attendance will be taken, and delegates and alternates will be distributed into small work groups to allow discussion of the various options presented.

Each group will have a feedback form that will be collected at the end of the session. As stated before, participants will not be asked to pick one model over the others. Instead, a series of exercises will allow us to collect information on the advantages and disadvantages of each model.

After the House of Delegates

- Use the feedback from the second meeting to construct a refined model for further discussion
- Additional Task Force work, discussion groups, and surveys will be scheduled to build consensus
- Bylaws allow special meetings of the House, so work can continue throughout the year

Following the House of Delegates discussion, the Task Force will develop a work plan to continue to define details and determine consensus. Any significant changes would require a revision of bylaws.

Current bylaws allow for special meetings of the House of Delegates, and given the importance of setting the path for the future, it is expected that this work will continue as quickly as possible and that special meetings will be used to further the momentum, rather than waiting for another year to pass.

This is an ambitious, important, and timely endeavor. We appreciate the time that you took to review this information and look forward to more input from you and your colleagues as we move forward.

Never has there been a more important time to ensure that physicians come together and do collective good for the patients that they serve, as we set the path for the next 150 years.